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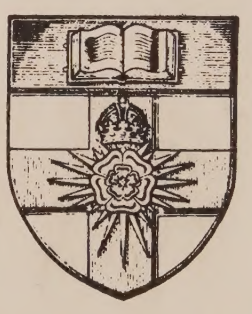

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HOUSE OF COMMONS

Eighth Report from the

COMMITTEE OF PUBLIC ACCOUNTS

Session 1985–86

NEXOS

Department of Trade and Industry

Ordered by The House of Commons *to be printed*
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The Committee of Public Accounts is appointed under Standing Order No 98 viz:

Committee of Public Accounts

98.(1) There shall be a select committee to be called the Committee of Publi Accounts for the examination of the accounts showing the appropriation of th sums granted by Parliament to meet the public expenditure, and of such othe accounts laid before Parliament as the committee may think fit, to consist of no more than fifteen members, of whom four shall be a quorum. The committee shal have the power to send for persons, papers and records, to report from time t time, and to adjourn from place to place.

(2) Unless the House otherwise orders, each Member nominated to the com mittee shall continue to be a member of it for the remainder of the Parliament

The cost of preparing for publication the Shorthand Minutes of Evidence taken before the Committe was £236.36.

The cost of printing and publishing this Report is estimated by Her Majesty's Stationery Office a £8,148.

THURSDAY 7 JULY 1983

The following were nominated as members of the Committee of Public Accounts:

Mr Dale Campbell-Savours
Mr Eric Cockeram
Mr Peter Hordern
Mr Michael Latham
Mr Robert Maclennan
Mr John Maxton
Mr Michael Morris
Mr Richard Needham
Mr William O'Brien
Mr George Park
Mr Nicholas Ridley
Sir Michael Shaw
Mr Barry Sheerman
Mr Robert Sheldon
Mr Michael Shersby

Mr Robert Sheldon was elected Chairman, 13 July 1983.

Subsequent changes in the membership of the Committee have been:

25 October 1983: Mr Richard Needham and Mr Nicholas Ridley discharged; Mr John Moore and Mr Fred Silvester appointed.

8 December 1983: Mr Barry Sheerman discharged; Mr Eric Deakins appointed.

1 February 1985: Mr John Maxton discharged; Dr John Marek appointed.

The present composition of the Committee is:

Mr Robert Sheldon, Chairman

Mr Dale Campbell-Savours
Mr Eric Cockeram
Mr Eric Deakins
Sir Peter Hordern
Mr Michael Latham
Mr Robert Maclennan
Dr John Marek
Mr John Moore
Mr Michael Morris
Mr William O'Brien
Mr George Park
Sir Michael Shaw
Mr Michael Shersby
Mr Fred Silvester

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EIGHTH REPORT

The Committee of Public Accounts has made further progress in the matter referred to it and has agreed to the following Report:

NEXOS

Introduction

C Session 83–84 15th port paras -29

1. In our Fifteenth Report of Session 1983–84 we commented upon the collapse of Nexos Office Systems Limited (Nexos), a wholly owned subsidiary of the National Enterprise Board (NEB) now part of the British Technology Group (BTG). Nexos was set up in January 1979 to develop and market an integrated office system based on word processors, facsimile machines and voice systems but in October 1981 the NEB decided to wind down the company, and it was finally put into liquidation in May 1983 with a then estimated loss of £31 million.

2. The Department of Trade and Industry (DTI) considered the principal reasons for the failure of Nexos were unsatisfactory arrangements negotiated by NEB with prospective suppliers to Nexos at the time the company was established, coupled with poor management of Nexos itself. In noting that the supply arrangements may have brought about the downfall of Nexos, we thought it doubtful that the loss of £31 million could be attributed in full to them. In this connection we drew attention to what appeared to us to be extraordinarily large trading losses of £17.8 million, given that Nexos's highest level of annual sales—in 1981—was only £8.9 million. We also noted that, though we were told that Nexos had been able to realise nearly book value on the disposal of most of its stock items other than for certain word processors, it was unclear whether any consideration had been sought in respect of a £5.2 million loss incurred on R&D expenditure or why debts of £0.6 million were written off. In view of the lack of information on these matters, and on the management deficiencies said to have been a contributory factor to the collapse of Nexos, we were far from satisfied that an adequate explanation of the loss had emerged, or that everything possible had been done to limit it. We accordingly recommended that DTI undertake a full investigation of the loss.

dence page p.2, page 65

3. Subsequently DTI commissioned an investigation which was carried out by an accountant on secondment to the Department from a private sector firm. We took evidence on his report in July 1985. The investigation report states that the latest estimate of the expected loss to NEB from the Nexos venture was £24.4 million, excluding any amounts realised from the liquidation process. As this figure was net of tax savings estimated at £7.6 million resulting from the utilisation of Nexos tax losses by NEB and its subsidiaries, we note that the overall loss to the taxpayer from the Nexos venture was about £32.0 million.

History of Nexos

as 4.8, 4.9, e 12

4. In April 1978, the NEB Board approved a strategy for the office equipment industry within which the NEB would make equity investments in industrial UK companies which would develop and produce key

elements for the office systems of the future. The NEB would a establish a new company to take over the marketing and support existing office machinery products and to co-ordinate, and where nec sary fund, the development of an integrated range of products for " electronic office". In September 1978 the Board approved a proposa establish a company, later to become Nexos, to fulfil this role, recogn ing that there were high risks involved.

paras 4.16, 4.38, pages 14, 17

5. The principal existing products to be marketed by Nexos were V 100 word processors and Muirhead facsimile machines and the relev business operations were to be transferred by their parent companies subsidiary companies—Logica VTS and Muirhead Office Syste Limited (MOSL)—in which the NEB would take minority shareholdin Several other companies in which NEB already held investments w expected to provide valuable products or skills for Nexos. Financ projections for 1978 to 1983 showed forecast Nexos sales of £18 million with a gross profit of £59.5 million, and it was estimated that, af all expenses, there would be a funding requirement of £18.5 million which NEB would provide £15 million.

para 4.17, page 14

para 4.11, 4.18, page 13

para 4.22, page 14

6. High risk factors identified by NEB were the required strength the Nexos management team and their ability to cope with projec growth rates for Nexos; the viability of the proposed corporate structu in particular Nexos's relationships with its suppliers; and the availabil of additional products. NEB considered that the suppliers' dependen on Nexos as a sales outlet, plus NEB's equity stakes, would give Ne sufficient control: and that, in the unlikely event that one of the suppli could not produce the next generation of products, Nexos could move another supplier with little disruption and with acceptable costs. As t Industry Act 1975 requires the Secretary of State's prior consent for NI investments in companies in excess of £5 million or 30 per cent of t voting rights, NEB sought DTI's approval for the initial £15 milli funding of Nexos in October 1978. This was given the following mon

paras 4.33, 4.38, page 16

para 4.39, page 17

App 4, page 70

App 6, page 73

7. The first Chairman of Nexos, acting in a non-executive capaci was the Head of the NEB division responsible for monitoring the inve ment and a member of his staff was appointed a director of the compa In their role as NEB employees these officers concluded NEB agr ments with Logica and Muirhead in January and September 1979 resp tively. Under the agreements the NEB made equity investments totalli £4.0 million in three Logica companies, along with a loan of £100,000 the Logica parent company, and acquired an equity investment £210,000 in MOSL. A corporate plan for Nexos, stated to be consist with the NEB strategy, was approved by the NEB Board in July 197

paras 12.4, 12.5, page 59

paras 4.40–4.46, pages 17–19

paras 5.14–5.21, pages 21–22

8. The supply and marketing agreements with Logica VTS a Muirhead were afterwards found to contain important deficiencies wh led to disputes between the parties, in particular with Logica VTS. T agreement with Logica VTS was for a period of 50 years and could broken only by mutual consent in the first two years, or by substan performance failure by one of the parties, insolvency, or change

paras 5.110, 5.149, 8.13–8.15, 9.24, pages 34 etc.

para 4.45, page 18

Q 2936

control. There were no arrangements for resolving disputes and the agreement effectively prevented Nexos from developing and buying word processors from any other manufacturers, but without Nexos having any real control over development, enhancement or quality of Logica products. Pricing arrangements were virtually on a cost plus basis, thus shielding Logica VTS from loss. The agreement with Muirhead contained no termination clauses, provided for cost plus pricing arrangements with nine month ordering periods and production lead times, and gave MOSL a first refusal right to any Nexos proposals for the development and manufacture of new facsimile products.

ras 5.31–5.33

9. During 1979, because the Nexos management considered the VTS 100 word processor and the Muirhead facsimile machines were respectively inadequate and obsolete, there was a major shift of emphasis from selling existing products to the development of new ones—notably the Logica 2200 word processor which was expected to be available for sale by July 1980, and a Delta communications management computer with voice systems from a US company called Delphi Communication Corporation, which was to be the centre piece of the integrated office systems, and which was expected to be available towards the end of 1980. Nexos also commissioned a number of feasibility and design studies and other development projects, including several with MOSL, and undertook development work itself. Over the period to end August 1981 Nexos spent some £7.3 million on R & D.

as 3.5, 3.6, 5.7, 5.13, 7

as 3.9, 5.48 5

p 3

10. Towards the end of 1979 Nexos started a rapid build-up of a large sales and marketing operation for the new products, based on the acquisition, for £890,000, of Ultronic Data Systems Limited, an office equipment sales and maintenance company with about 100 staff, whose principal existing product was an imported Japanese Ricoh word processor. Nexos started selling Muirhead's existing office facsimile machines in January 1980 and Logica's existing word processors in the following month.

a 3.11

as 5.8, 5.12

a 5.42

11. The NEB official who was the first Chairman of Nexos had resigned from the NEB in October 1979 and thereafter the company was without a Chairman until February 1981. In February 1980 a new NEB Board—the previous Board had resigned in November 1979—noted that the Nexos approach carried high risk and that it might be necessary to obtain independent advice on the company's business strategy when the Board considered Nexos's 1980 corporate plan. An independent review was commissioned by the Board in July 1980. Pending its outcome NEB funding of Nexos was increased, with DTI approval, by £0.8 million, and Nexos was told that it would have to live within the revised total funding of £15.8 million until the review was completed. By Autumn 1980, by which time Nexos had received funding of £14.9 million from NEB, Nexos was employing some 350 people with overhead and development costs running at £15 million a year, while sales turnover was then equivalent to only £6.75 million a year. The 2200 word processor had not met its July 1980 introduction date and an improved version of MOSL's K442G facsimile machine had not become available for sale until September 1980, some six months late.

a 5.40

a 5.44

as 5.67, 3, 5.80

as 5.76–5.99

as 5.59,

paras 5.68–5.70 12. The independent review team, comprising private consultants a accountants, assisted by NEB staff and headed by an NEB Board dire
para 5.87 tor, reported in October 1980. The review team concluded that the Nex strategy was sensible but ambitious, and carried high risk. It involv capturing significant shares of the UK and European markets for offi systems with a product—the 2200 word processor—which, though co
para 5.86 petitive, was not outstanding. On the basis of the report and a revis (October 1980) corporate plan for Nexos, NEB requested DTI consent
para 5.89 increase its funding of Nexos to a total of £35.1 million. The Boa informed DTI that Nexos had suffered from the production difficulties its suppliers (Logica VTS and MOSL) in its first year of operation b noted that Nexos's unique advantage would be the Delta processor if t
para 5.88 was successful. Though sensitivity analyses by the review team show that total funding of £50 million might be needed to develop Nexos to t point where it could generate adequate profits, the most gloomy analys showed that the company could be worth £100 million by the end of 19
para 5.92 as a result of such funding. NEB added that in order to limit risks it w tightening its monitoring controls over Nexos. It also intended to und take a further comprehensive review of Nexos in mid-1981 to che satisfactory progress in resolving a number of major issues, includi Nexos's relationships with its suppliers.

paras 5.91, 5.95 13. Although the NEB had pointed out to DTI that there was so urgency for a decision on further funding of Nexos, the Department to
para 5.82 the view that the Nexos case needed careful consideration. In Novemb
paras 5.96–5.99 1980 Nexos drew down the last £0.9 million of its approved £15.8 milli funding and then ran into a cash crisis. In December 1980 NEB inform DTI that without further finance Nexos would have to go into immedia liquidation and that it was believed that this would cause Logica VTS fail, as well as having adverse consequences to MOSL. To keep Nex going until the end of February 1981 while the NEB sought private sect
para 5.101 financing for the company, DTI approved further NEB funding of £5 million. In January 1981 DTI approved a further £1 million funding f Nexos to keep it going to the end of April 1981.

paras 5.116,5.105–5.114 14. Commercial sales of the 2200 word processor commenced in Jan ary 1981. By this time Nexos directors were pressing NEB for a merger Nexos and Logica VTS which they considered necessary to resolve t problems in their relationship with Logica VTS, but the NEB considere that the problems were of an operational nature and therefore primarily
paras 5.101, 5.102 matter for the Nexos management to resolve. In February 1981 NE reported to DTI that the 'drip-feed' funding of Nexos was undermini market confidence in the company and would damage prospects attracting private sector finance for it, and requested additional fundi of £13 million for Nexos to bring total funding to the £35.1 millio envisaged in the company's October 1980 Corporate Plan. DTI appro
paras 5.103, 5.104 was given on the understanding that the further funding was to be t final commitment: if Nexos did not succeed commercially it was to b wound up with closure costs contained within the £13 million. In Ma 1981 three non-executive directors appointed to Nexos to strengthe its management reported that the supply and marketi

agreement with Logica VTS was very restrictive and that it was essential that Nexos or NEB acquired Logica VTS, but subsequent NEB proposals for a merger foundered because the Logica parent company was not prepared to sell its shareholding.

as 5.116, 26–5.132

15. The introduction of the 2200 word processor in January 1981 led to increasing Nexos sales in the period up to March 1981 but sales levels thereafter fell back, and overhead and development expenditure continued at several times the amount of gross profit earned. Failure to achieve target sales was attributed by the Nexos management to inadequate facilities and poor reliability of the 2200 word processor, its high transfer price from Logica VTS, increased competition for facsimile products, and continued lack of market confidence in the future of Nexos, in particular by large customers concerned with servicing arrangements. In September 1981, because of the failure to achieve adequate sales levels and to attract private sector funding into Nexos, NEB decided to run down Nexos and dispose of its activities. At that date, none of the Nexos new product developments, with the exception of the 2200 word processor, had reached the market place.

as 3.17, 36–5.137

Reasons for the failure of Nexos

as 1.5, 1.7

2936

16. The investigating accountant concluded that the principal reason for the failure of Nexos was that its management tried to do too much too quickly, creating a much larger organisation, with higher outgoings, than was justified by either sales or the amount of approved funding by NEB. He commented that Nexos had embarked upon a business plan which was critically dependent on early market success of one product—the 2200 word processor—but had failed to recognise and to plan for the possibility of unforeseen delay in the development of that product. Though Nexos management had recognised in March 1980 a forecast three month slippage to September 1980 in the availability of the 2200 word processor for sale—in the event as noted in paragraph 14 it was not available for sale until January 1981—the management had continued to build up the Nexos sales and marketing organisation.

ra 5.59

17. Though the investigating accountant confirmed therefore what we were told in November 1983 that poor management of the company was the main cause of the Nexos failure, he reached a rather different conclusion about the significance of the unsatisfactory agreements which NEB had negotiated with suppliers to Nexos. He thought that the difficulties for Nexos attributed to some of these agreements had been over-stated. We asked DTI for an explanation.

2836

18. The Department acknowledged that they had been wrong to attach so much importance to the supply and maintenance agreements in relation to the failure of Nexos. They explained that, though the agreement with Logica VTS had contained obvious flaws, it was possible that they had been too much influenced by the Nexos management and NEB officials in the importance they had attached to it. The Department's conclusion in November 1983 had reflected the then state of their knowledge about Nexos. The investigating accountant had had access to Nexos and NEB records to which DTI had not had access, and the

investigation had brought additional knowledge which had led to a new
Q 2959 judgment. The investigation report showed that, as a result of the subs-
tantial build-up of Nexos before the introduction of the 2200 word
processor, the Nexos management had put the company in the position
Q 2936 that if adequate sales were not achieved Nexos would collapse. A very
high overhead cost had been incurred without the sales, or certain
Q 2974 expectation of sales, to justify it, and it was now evident that the Nexos
management had taken an unwise gamble.

19. While we accept that the results of the investigation indicate that
the Nexos management acted unwisely in handling the public monies
entrusted to them, and had launched an ill-judged expansion of Nexos,
we doubt if it would be right to attribute the failure of the company to this
alone. The investigation report reveals very clearly there were other
earlier, contributing factors; also failures on the part of NEB and DTI to
recognise danger signals and to take appropriate action. We comment on
these further below.

Change in Nexos Strategy

20. The change in Nexos strategy in 1979 from one based on the sale of
existing products to one with a greater emphasis on the development of
new products substantially increased NEB's investment risk which the
para 1.4 Board had recognised at the outset was high. But the investigation report
states that it was not clear to what extent the NEB Board and NEB senior
executives had endorsed this change of strategy or had recognised the
Q 2938 way Nexos was developing. Indeed DTI told us that they suspected it had
not appeared to be a fundamental change to the NEB. It was however this
change of strategy which led to the company eventually becoming depen-
dent on the success of a single product (the 2200 word processor) over
which it had so little control. By the time NEB had become aware of this
situation following its review of Nexos in July 1980, the company had
largely developed the excessive sales, development and headquarters
organisation which, as a result of inadequate sales, brought about its
downfall.

Supply and Marketing Agreements

21. As noted in paragraph 8 the supply and marketing agreements
with Logica VTS and MOSL were deficient in a number of important
paras 4.33, 5.31 respects. It appears that in at least two of these respects the agreements
did not comply with NEB directions. First, the agreements prevented
Nexos switching to other word processor and facsimile manufacturers in
the event that Logica VTS and MOSL failed to meet development and
paras 4.48, 4.49, 5.33 production commitments; second, the agreements did not provide for
specific prices for existing products (although a side agreement was
reached with MOSL) or establish an agreed pricing framework for new
products.

para 4.52 22. While we accept the investigating accountant's conclusion that the
difficulties with the agreements were not the root cause of the failure of
Nexos—contrary to the impression we were given in November 1983—it
seems to us that the agreements, like the changed strategy for

Nexos, did in fact have more than a little bearing on that failure. This is because Nexos planning and financial projections were geared to the supply of quantified numbers of products of marketable quality giving quantified gross profit margins on sale to customers. But Nexos had no effective recourse to Logica VTS for compensation in respect of delivery delays, little control over development costs and bought-in prices, and was unable to turn to another word processor manufacturer. Though responsible contingency planning by Nexos for possible delays in the introduction of the 2200 word processor would have lessened the financial consequences to Nexos, the basic flaws in the supply and marketing agreement would have remained, and would have needed to be resolved, as would have those in the supply and marketing agreement with MOSL.

2939 2957 23. Whether arrangements satisfactory to Nexos and Logica VTS to resolve the difficulties between the companies could have been negotiated is a matter for conjecture. As DTI told us, Logica VTS were perfectly entitled to stand on the agreement made; and, as the investigating accountant pointed out, Logica VTS stood to benefit if Nexos foundered. This was because the rights to the 2200 word processor would have reverted to Logica VTS even though its development had been finance wholly by Nexos. Logica VTS would then have been able to make other arrangements for the marketing of the word processor. Whether or not the seeds of Nexos' collapse were sewn in these unsatisfactory agreements, an unquestionable consequence of them was that Nexos suffered substantial financial losses on their termination when the decision was taken to wind-down the company, and we comment on this matter in paragraphs 38 to 42.

Funding of Nexos

ras 5.95–104 24. While DTI were considering NEB's October 1980 application to increase Nexos funding to £35.1 million and were awaiting the outcome of the Board's efforts to attract private sector finance into the company, the company was provided with drip-feed funding. £5.3 million was made available in December 1980 and £1.0 million in January 1981. The accountant's report concludes that this method of funding resulted in uncertainty as to Nexos' future and that this caused damage to Nexos. In February 1981 the Department approved a further final funding of £13 2956 million. DTI told us that the options facing Ministers at that time were to wind-up Nexos, to continue to drip-feed it in the hope that private sector finance would be found, or to authorise additional funding to the level envisaged in the company's corporate plan. But winding-up of Nexos would have cost £5 million, with little prospect of recovering any significant part of the £22 million already invested in the company, while further drip-feeding of the company would have further undermined its credibility and market prospects, and led to a costly and lingering death. In favour of the third option of full funding were good initial sales of the 2200 word processor, some indications that private sector finance might be found if Nexos succeeded in the market place, and the decision of the NEB to strengthen the management of Nexos by the appointment of three non-executive directors including a Chairman. In these circumstances it had seemed right to continue to back

Q 2940 Nexos for a limited period and with a limited amount of money. It is concern, however, that in spite of the confidence placed by DTI in th new Nexos directors, their views seem, from the evidence received, nev to have been sought with regard to subsequent events.

25. There is little doubt that the decision to drip-feed Nexos unde mined potential customer confidence in the company. It was unfortunat therefore that DTI took so long to reach a final decision on whether t provide the additional funding up to the level requested by Nexo Turning to that decision, the fundamental question which had to b addressed was whether additional funding carried with it the possibility the company's survival and eventual viability. We note that at that tim as DTI admitted, the company's future success was being gambled on th success of a single product. We doubt whether such a high risk ventur would have attracted private sector investment but recognise that th Department were faced with equally unpromising alternatives. In th event NEB only made available to Nexos £10 million of the approve additional funding of £13 million, but all of this sum was subsequent lost.

Control and Monitoring of Nexos

(a) NEB Role

26. As the single shareholder in Nexos the NEB had full responsibili for approving the strategy of the company and its corporate plans, and fo para 4.9 monitoring compliance with them. We note however that the NEB overall strategy for office systems development had also resulted in th Board's investments in both Logica and MOSL. It seems to us that th implementation of the Board's strategy in this way must have put th NEB in the position of having divided loyalties when the conflicts interest between Nexos and Logica VTS arose. There appears to hav been an unwillingness on the part of the NEB to take positive action resolve the difficulties between the companies; we note that any solutio benefiting Nexos would have to have been at the expense of Logica VT para 5.96 and that the Board was concerned that a Nexos collapse might brin App 9 down Logica VTS. We also observe that, although NEB Board minut para 55 in October 1980 noted that NEB should seek as a matter of urgency para 5.111 resolve issues affecting Nexos relationships with its suppliers, five montl later, in February 1981, the Board placed the onus of responsibility fo resolving the difficulties with Logica VTS back on the Nexos manag ment. With the benefit of hindsight it seems that, as a result of its million investment in Logica, NEB was unable to act in the sole interes of Nexos, in which its eventual investment was nearly eight times large Thus we suspect that the NEB's control and monitoring role in respect Nexos may have been undermined at the outset. More certainly, it is cle para 4.33 that the NEB's original expectations of the advantages to Nexos from th Board's equity investments in Nexos suppliers, to which we have referr in paragraph 4, were not fulfilled.

27. We asked DTI about the adequacy of the NEB's monitoring Q 2982 Nexos. They told us that they had received a report in April 1979 th NEB's own auditors were generally satisfied with NEB's procedures f

2985 2977 2938 s 2977, 2986 2973 2966 ara 12.1

monitoring investments, but it was now clear from events that the Board's monitoring of Nexos was unsatisfactory. Given the drastic changes in the NEB Board over the period of the Nexos investment—four chairmen and three chief executives with an entirely new Board of Directors from November 1979—and taking account of NEB's other, more important tasks—the rescue operations for British Leyland and other companies—the Department thought that the NEB's failure to monitor adequately what was happening in Nexos, though not excusable, was understandable. Furthermore, it had to be remembered that NEB's remit was to invest in high risk ventures and that every such venture could not be expected to succeed. In DTI's view, there were two lessons on monitoring from the Nexos case. First, that monitoring was a very difficult task which needed a large amount of attention; second, that monitoring staff should not be involved in the management of the investment as this made it difficult for them to be wholly objective and impartial. In this connection the investigation report had noted that at the time Nexos was established it was NEB's policy that officials making investments should be responsible for monitoring them on the grounds that the officials had the motivation to make the investments succeed and had detailed knowledge of the investee companies including their management.

2965

28. We appreciate the difficult circumstances under which the NEB operated including also that there was a loss of confidence within NEB, with a high turnover of staff during 1979, stemming from the uncertainty at that time about the Board's future. Nevertheless, as DTI pointed out, the job of the NEB was to monitor and help run businesses. It is clear that NEB did not give Nexos, with its recognised high risk, the attention it deserved and needed in the critical aspects of strategy, policy and planning, and in monitoring its activities. We believe that the failure by NEB properly to discharge its control and monitoring role contributed significantly to the failure of Nexos. Notably,

(a) it approved and implemented the 'building block' approach of companies in which it had invested for its office system strategy and negotiated the supply and marketing agreements which led to the difficulties between Nexos and its main suppliers;

(b) it allowed the change in Nexos strategy in 1979, with the greater risks entailed, from selling existing products to greater emphasis on the development of new products for sale;

(c) it failed to recognise, and therefore to decelerate, the rapid build-up of Nexos in the first half of 1980;

(d) it did not appoint independent non-executive directors to the board of Nexos until February 1981.

as 4.25, 6

We further note that the investigating accountant found no evidence that NEB made sensitivity analyses of the original 1978 proposals and financial projections for Nexos.

PAC Session 1983–84 15th Report para 29

29. Accordingly, in our opinion, the NEB must bear a significa measure of responsibility for the failure of Nexos. Indeed, as we pointe out in our Fifteenth Report of Session 1983–84, as the Board commi sioned Nexos, and was its parent body, it must bear the ultima responsibility.

Qs 2942–2944

30. We strongly endorse the lessons on monitoring which DTI hav identified from the Nexos case. In this connection we note that, with th same NEB officials having responsibility for both establishing an monitoring Nexos, the NEB Board may not always have received impa tial advice on the company and its progress. We also note, and welcome the assurances given to us by the Chairman of BTG of improved monito ing within the Group for its remaining significant investments. On thi matter, though we agree with BTG's observation that monitoring c investments should extend much more deeply than just the appointmer of non-executive directors, we emphasise the importance of the contribu tion to the monitoring process that non-executive directors can make. W have recently commented upon the role and responsibilities of non executive directors appointed by Government departments and by statu HC 33 tory bodies financed from public funds in our First Report of Sessio 1985–86.

(b) DTI role

PAC Session 1983–84 15th Report C&AG's Memorandum paras 17–23

31. Revised guidelines for NEB issued by the Secretary of State i June 1980 specified that NEB had responsibility for operational an commercial decisions and that the Secretary of State would not use hi statutory powers, under the Industry Act 1976, to intervene in day to da matters. In a Memorandum submitted to the Committee of Sessio 1983–84 the Comptroller and Auditor General (C & AG) noted tha DTI's monitoring of NEB was based on the Board's corporate plan, o quarterly progress reports from the Board, and its audited annua accounts. The quarterly reports contained brief descriptions of individua investments, and DTI officials kept in frequent contact with NEB o large investments. DTI told the C & AG that they had not sought t inspect the records of NEB Board meetings or associated papers for th reason that revised guidelines issued to NEB gave the Board responsi bility for operational and commercial decisions and for the day to da affairs of its companies. Accordingly, DTI did not attempt to second guess NEB's commercial judgment in monitoring the Board's acquisitio and management of investments.

PAC Session 1983–84 15th Report para 27

App III paras (e)(i), (e)(ii)

32. In our Fifteenth Report of Session 1983–84 we expressed ou concern that neither NEB, the independent review team, nor DTI ha recognised sufficiently early the seriousness of the fundamental flaws i the Nexos supply arrangements (see paragraphs 21 and 23 above). I written evidence to us at the time DTI had told us that though they ha been aware from Autumn 1980 of the supply problems experienced b Nexos, it was not until NEB started to dispose of its interests in Nexos i October 1981 that the department became aware that the suppl difficulties had had their source in the supply and marketing agreement themselves.

as 1.9, 13
p 10 idence page
ra 11.7

33. The investigation report disclosed that DTI were in fact informed that the difficulties stemmed from the supply and marketing agreements in letters from the Nexos directors to the Secretary of State in February 1981. The Accounting Officer of the Department has apologised to us for unintentionally misleading us on this point and for not drawing our attention to those letters in the Department's earlier evidence to us. Given the significance of the letters—we comment in paragraph 35 upon the central issue of further funding for Nexos which was raised in them—we are surprised and concerned that such an error could have occurred. We also note that the investigating report implies that DTI may have been aware of the supply problems with the 2200 word processor some two or three months earlier than October 1980. We emphasise the importance we attach to accurate evidence and we trust that DTI will take appropriate steps to ensure that full and accurate information is supplied to the Committee in future.

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34. The February 1981 letters from the Nexos directors stated that without strong resolve on the part of the Government and NEB to bring about a merger of Nexos and Logica VTS, the Nexos directors could not recommend any further funding of Nexos given the objective of attracting private sector investment in the company. We asked DTI why they had not followed-up these letters. They told us that alarm bells about Nexos had rung within the Department during 1980 which was why no immediate decision was taken on NEB's October 1980 request for additional funding, as Ministers had wanted to consider the matter thoroughly. The letters from the Nexos directors had been received on 19 February 1981 following a morning meeting that day between the Chairman of NEB and Ministers to discuss the situation of the company. Although the letters themselves had not therefore been available, their content had been part of the overall discussion. However the possibility of a merger was not raised as this was not a course of action that was considered practicable. Neither the Government nor NEB could insist upon Logica VTS giving up its rights under its supply and marketing agreement or merging with Nexos. Ministers had therefore paid little regard to the letters which they considered were an indication of the poor quality of Nexos management rather than of what ought to be done for the future.

35. We think there is room for doubt whether the matters raised in the letters could have received proper examination at the meeting between the NEB Chairman and Ministers in the absence of the letters themselves; also, whether the letters received proper consideration within DTI prior to their sanctioning the final £13 million funding for Nexos, which we note was the day after the meeting with the NEB Chairman. Although we understand why the Department and Ministers had misgivings about the quality of Nexos management, it seems to us that it was imprudent to authorise further funding without first obtaining an NEB commentary on the points made by the directors. Additional information about the problems facing Nexos, in particular its difficulties with its supply and marketing agreements, would have enabled a more informed judgment by DTI of the prospects of the company succeeding, following the provision of further funding.

Q 2938
Q 2965

36. DTI pointed out that they had been at one remove from what wa happening in the company and that NEB was responsible for monitorin Nexos while DTI was responsible for monitoring NEB. They also told u that, as the responsibility for Nexos rested with the NEB, and as th Board was composed largely of businessmen, it would have bee presumptuous of the Department to have instructed NEB on how to ru Nexos. While we recognise DTI's arms-length relationship with NEB, w consider this comment to have been somewhat disingenous. We accep that departments in their relationships with public sector investmen bodies such as the BTG and the Development Agencies should no attempt to 'second guess' the bodies' investment decisions. In dealin with large investments, however, we would certainly expect them t confirm that the soundness of business and financial plans and projec tions for enterprises in which they had invested had been fully appraised and to obtain clear statements of quantified risks and performanc yardsticks for monitoring progress. In our earlier Report on Nexos w noted that as DTI had accepted unquestioningly NEB's original forecast for Nexos in 1978 they must share part of the responsibility for th eventual failure of Nexos. We now further observe that, notwithstandin the NEB's auditors' report that NEB's monitoring of investments wa adequate, the Board's difficulties in 1979 and 1980, to which we hav referred in paragraphs 29 and 30, should have alerted DTI to the need fo extra vigilance over NEB activities including Nexos.

Paras 11.2, 11.7

37. Furthermore, it is evident from the report that the Department had direct knowledge of the company from Nexos staff as well as from quarterly reports from NEB; that they were aware of the change in Nexos strategy and that there were supply problems as early as the summer of 1980. Although we note that DTI did not unquestioningly approve NEB's application for the final funding of Nexos in February 1981, it seems to us that the Department were unduly reliant on the Board's judgment with regard to Nexos. In our view DTI must share part of the responsibility for the failure of Nexos. However we note with satisfaction that, as a result of the Government's acceptance of our earlier recommendations on DTI's monitoring of BTG, improved arrangements have been introduced by the Department along with lower delegated powers to the BTG for investment decisions.

Disposal of Nexos assets

App 3

38. By September 1981, when NEB decided to run-down Nexos, the company had spent some £1.4 million in acquiring fixed assets and had equipment stocks, mainly word processors and facsimile machines, which had cost some £4.2 million. It had also by that date contributed £7.3 million to the development of new products, including £2.6 million on the 2200 word processor, over £2.4 million plus on Delta, and £0.9 million on facsimile products. In our previous Report we noted that DTI had been consulted by NEB on the disposal of Nexos assets and stocks, and had later obtained an assurance from the Board that press allegations that stock items were sold too cheaply were ill-founded, in that nearly book

PAC Session 1983–84 15th Report para 28

value had been realised on most stock items other than those purchased from MOSL. We noted, however, that it was unclear whether any compensation had been sought for R & D losses.

39. The investigating accountant examined in some considerable depth the disposal of Nexos's word processing and facsimile businesses, the principal stocks held by Nexos and the reasons for the R & D losses. His report shows that there were no meaningful termination clauses in the supply and marketing agreements with Logica VTS and MOSL, and that the rights to developed and development products rested with these companies in the event that Nexos went into receivership. In fact both Logica VTS and MOSL had possible claims for damages under the supply and marketing agreements and, though Nexos had counter claims against Logica, in both cases it was in a very weak bargaining position. Ultimately Nexos managed to sell its word processing business to ICL for the book value of Nexos stocks, with Nexos and Logica VTS waiving their claims against each other, and NEB selling to Logica Securities its equity shares in Logica companies at a loss of £560,000. For its facsimile business, Nexos reached an agreement with Muirhead which provided for MOSL to acquire for just £1 all facsimile stocks held by Nexos and supplied by MOSL and, for a further £1, all facsimile stocks of Japanese origin in transit to Nexos through MOSL. In addition NEB contributed £100,000 to MOSL towards re-establishing its marketing operations while Muirhead transferred into MOSL the facsimile service business of one of its subsidiary companies along with tangible assets of some £450,000.

pp 12, 13

40. As a result of excessive ordering levels in relation to eventual actual sales the number of MOSL supplied facsimile machines held by Nexos at the end of October 1981 was 878. As these machines had cost £1.82 million we asked why they had been sold for only £1. The investigating accountant told us that at that time Nexos held some 600 facsimile machines of Japanese origin with a possible sale value of the order of £1,000 each, but that remaining machines manufactured by Muirhead were virtually obsolete with little sale potential. But he stressed that it was unlikely that there was any real alternative to a Nexos settlement with Muirhead. This was because any other potential bulk purchasers of Nexos stocks would have needed spare parts and service back-up from Muirhead which therefore had to be a party to any sale arrangements. Given this unsatisfactory situation NEB had obtained legal advice, and had negotiated what he thought was the best that could be achieved in the circumstances.

pp 12 Qs 947–2951

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41. The investigating accountant also examined Nexos's involvement in the Delta project of the US company Delphi Communications Corporation, a subsidiary of the Exxon group. Under an agreement approved by the NEB Board in July 1979 Nexos paid an initial royalty of $2 million, and committed itself to further royalties of not less than $2.15 million over the following ten years, for the exclusive right to manufacture and sell the Delta office communications package within Europe, and further undertook to spend £1 million before 1984 on the development of specific Delta applications. By early 1980 it had become

ra 6.1

ras 6.6–6.9

ras 6.15, .6

apparent that Delphi's primary development of Delta would take mu
longer than expected and that the product would not be available for sal
para 6.20 as originally expected, by July 1980. In the event, no sales of Delta we
App 11 made by Nexos or customer orders received for it. Following NEE
decision in September 1981 to wind-down Nexos, efforts were made
dispose of the Delta licence, but no buyers could be found. Attempts
sell the licence back to Exxon also failed as Exxon was not interested
the European end of the Delta project. Legal advice obtained by th
NEB stated that Delphi could be entitled to damages from Nexos appro
imating to the minimum royalties payable over the ten year term of th
licence agreement, along with any monies owing on Nexos's outstandi
contracts for purchase of Delta systems, and that it was possible th
Delphi could also sue for the £1 million which Nexos had agreed to inve
in the development of Delta applications. In November 1981 an agre
ment for the termination of licence was concluded at no further net cost
Nexos.

42. We note that the supply and marketing agreements with Logi
VTS and MOSL not only led to less than satisfactory realisation settl
ments for the disposal of Nexos's word processor and facsimile business
and stocks, but also to the loss of ownership rights to products who
development Nexos had financed at a combined cost approaching £3
million. We also note that the agreement for the Delta project provide
Nexos with an exclusive licence to manufacture and sell Delta products
Europe which in the event, despite Nexos expenditure of more than £2
million on the project, proved worthless. In this connection, we furth
note that Delphi, some nine months after the termination of Nexos
Delta licence, closed down its Delta operations from which we assum
that Delta was not viable. We find it astonishing that the NEB, bearing
Q 2965 mind that it was composed largely of businessmen, could have entere
into agreements which, due to the absence of elementary safeguard
provided to be so damaging to Nexos.

General Conclusions

43. The investigation report has shown that our earlier suspicions tha
the full facts about the Nexos loss may not have emerged were full
justified. We have found the report extremely informative and revealin
although we were disappointed that it did not analyse or comment on th
way the NEB and DTI discharged their own responsibilities with regar
to the Nexos investment. It is however now clear that responsibility fo
the failure of Nexos was fairly widespread. In our view the project wa
badly planned, incompetently managed and inadequately monitored. W
also note, with very considerable disquiet, that the reasons for the Nexo
loss differ significantly in content and in emphasis from those previousl
given to us. The inference must be that NEB and DTI were insufficientl
informed about Nexos, and could not have been discharging their respon
sibilities properly, and we are satisfied from our examination that this wa
Q 2967 indeed the case. We therefore welcome DTI's assurance that, unde
revised policy and revised arrangements for BTG, no repeat of Nexo
should be possible.

44. We would also emphasise our concern that we were obliged to ask DTI to carry out the investigation into Nexos. This was necessary because the C&AG, despite his prime responsibility for the audit of public expenditure, has no rights of access to the accounting and other records of either Nexos or the NEB. In our view it is unacceptable that an accountant seconded to DTI was able to investigate and report on Nexos, but that the C&AG was unable to do so. Parliament has a right to expect that when public funds are misused on the scale that occurred in this case the C&AG should be able to undertake direct investigations and report his findings. More generally, the Nexos case reinforces the view expressed by previous Committees that all bodies in receipt of public funds should be accountable to Parliament through examination by the C&AG. We look forward to a suitable opportunity for Parliament to bring about this change.

SUMMARY OF MAIN FINDINGS AND CONCLUSIONS

45. (a) The loss to the taxpayer from the Nexos venture was £32.0 million excluding any receipts that may be realised from the final liquidation process (Paragraph 3).

(b) The principal reason for the failure of Nexos was that its management created a much larger organisation, with higher outgoings, than was justified by either sales or the amount of funding approved by NEB (Paragraph 16).

(c) The early change in the strategy of Nexos from one based on the sale of existing products to one with a greater emphasis on development of new products substantially increased NEB's investment risk and was a contributory factor to the company's failure in that it led to Nexos becoming dependent on the success of a single product—the 2200 word processor (Paragraph 20).

(d) NEB negotiated supply and marketing agreements with Nexos's main suppliers which were deficient in a number of important respects: they made no provision for compensation in respect of delivery delays, provided little control over development costs and bought-in prices, and prevented Nexos from switching to other suppliers (Paragraph 22).

(e) The £6.3 million 'drip-feeding' funding of Nexos between December 1980 and February 1981 undermined potential customer confidence in the company. The decision to provide a final funding of £13 million was a gamble on the success of a single product which in the event resulted in the loss of the £10 million actually made available to Nexos (Paragraph 25).

(f) The investment by the NEB in the companies who were the main suppliers of Nexos created a potential conflict of interest which we suspect may have undermined the NEB's control and monitoring responsibilities (Paragraph 26).

(g) Although we appreciate the uncertainty at the time about the future of the NEB, it did fail to exercise proper care in its monitoring of Nexos; and, as the parent body of Nexos, must

bear the ultimate responsibility for its failure and for the £3 million loss of public monies (Paragraph 28).

(h) We strongly endorse the lessons on monitoring identified by DTI. We also emphasise the importance of the contribution to the monitoring process that non-executive directors can make (Paragraph 30).

(i) Information available to DTI should have alerted them to the need for extra vigilance over Nexos's activities and the Board's own monitoring arrangements; and the Department acted imprudently in not following-up matters raised in letters from Nexos directors in February 1981 before sanctioning the final funding of Nexos. DTI must therefore share part of the responsibility for the failure of Nexos (Paragraphs 35 to 37).

(j) The unsatisfactory realisation settlements for the disposal of Nexos's main business activities and stocks, and the failure to obtain financial or other consideration for R&D expenditures, were due to the absence of elementary safeguards for Nexos in the original supply and marketing agreements (Paragraph 42).

(k) It is unacceptable that the C&AG was unable to investigate and report on the Nexos loss. This case reinforces the view expressed by previous Committees that all bodies in receipt of public funds should be accountable to Parliament through examination by the C&AG (Paragraph 44).

PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT

Session 1984–85

MONDAY, 15 JULY, 1985

Members present:

Mr Robert Sheldon, in the Chair

Mr Dale Campbell-Savours
Mr Eric Deakins
Sir Peter Hordern
Mr Michael Latham
Mr Michael Morris
Sir Michael Shaw
Mr Michael Shersby
Mr Fred Silvester

Sir Gordon Downey, KCB, was further examined.

The Committee deliberated.

Mr C H A Judd was called in and further examined.

The Report of the Department of Trade and Industry on Nexos and the Memorandum on the Monitoring of the British Technology Group were considered.

Sir Brian Hayes, KCB, Permanent Secretary, Department of Trade and Industry, Mr Colin Barker, Chairman, British Technology Group and Mr Russell Ford, Deputy Director, Industrial Development Unit, Department of Trade and Industry, were called in and examined.

[Adjourned till Monday, 22 July at a quarter to Five o'clock.

* * * *

Session 1985–86

WEDNESDAY, 20 NOVEMBER, 1985

Members present:

Mr Robert Sheldon, in the Chair

Mr Eric Cockeram
Mr Eric Deakins
Sir Peter Hordern
Mr Michael Latham
Mr Robert Maclennan
Mr William O'Brien
Mr George Park
Sir Michael Shaw

Mr David Myland, Deputy Comptroller and Auditor General, was further examined.

The Committee deliberated.

Draft Report (Nexos), proposed by the Chairman, brought up and read.

Ordered, That the Draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 23 read and agreed to.

Paragraph 24 read, amended and agreed to.

Paragraphs 25 to 45 read and agreed to.

Resolved, That the Report, as amended, be the Eighth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order Number 92 (Select committees (reports)) be applied to the Report.

* * * *

[Adjourned till Monday next at a quarter to Five o'clock.

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Monday, 15 July, 1985

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BRITISH TECHNOLOGY GROUP	
Mr C Butler	100

MEMORANDA INCLUDED IN THE MINUTES OF EVIDENCE

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MINUTES OF EVIDENCE TAKEN BEFORE THE COMMITTEE OF PUBLIC ACCOUNTS

MONDAY 15 JULY 1985

Members present:

Mr R Sheldon, in the Chair

Mr D Campbell-Savours
Mr E Deakins
Sir Peter Hordern
Mr Michael Latham
Mr M Morris
Sir Michael Shaw
Mr M Shersby
Mr F Silvester

IR GORDON DOWNEY, KCB, Comptroller and Auditor General, called in and further xamined.

LETTER AND ENCLOSURES SUBMITTED BY THE DEPARTMENT OF TRADE AND INDUSTRY (PAC 171A, 171 & 177)

I am enclosing with this letter 35 copies of the Department's report on Nexos, reparatory to the Committee's provisional session on 22 July to consider this matter. The Committee has indicated that it may also wish to consider two other matters concerning the British Technology Group on that day: the price obtained by the BTG for its holding in nmos[2]; and the current arrangements for the Department's monitoring of the BTG[3]. I am, herefore, also submitting with this letter 35 copies of notes by the Department on these wo subjects.

The report on Nexos is the outcome of a full and thorough investigation which has been arried out by Mr Russell Ford, a senior accountant on secondment to the Department rom Deloitte Haskins and Sells. During the course of the investigation it has emerged that ome of the evidence given to the Committee when it considered this matter during the 983/84 session should be revised in the light of what we now know. There are two articular aspects to which I should like to draw the Committee's attention.

First, the report takes a somewhat different view as to the principal reasons for Nexos' ailure from that expressed in the Department's earlier evidence. The Committee may ecall that the Department originally told the C&AG and the Committee that it believed he principal reasons for the failure of Nexos were the unsatisfactory nature of the ommercial agreements which the National Enterprise Board had negotiated with rospective suppliers to Nexos at the time the company was established, coupled with poor anagement of Nexos itself.

The present report on Nexos concludes that though the agreements did have a number of eficiencies this was not a principal factor in Nexos' failure; rather, the most significant eason was that its management increased the size and outgoings of the organisation to too igh a level, given actual and likely sales revenues.

The second matter to which I should like to draw the Committee's attention concerns the epartment's knowledge of deficiencies in the supply and marketing agreements. In a note ving information requested by the Committee (and published as Appendix III to the ommittee's fifteenth report of the session 1983-84), the Department said:

AC 171 (printed below, pp 3 to 97)
AC 176 (not printed)
AC 177 (printed below, pp 98 to 99)

"Although the Department was not aware of the details of the supply agreements, it was aware from the autumn of 1980 of supply problems with the products to be marketed by Nexos. However, it was only when the NEB became involved in negotiations to dispose of its interest in Nexos that it become apparent to the Department that these difficulties had their source in the structure of the supply and marketing agreements themselves."

It has been pointed out that this does not seem consistent with the fact that letters were sent direct to the Secretary of State by some of the directors of Nexos in February 1981, drawing attention to the allegedly unsatisfactory nature of the relationship between Nexos and Logica VTS. Having reviewed the contents of these letters I have to say that the evidence given earlier to the Committee was mistaken, in that it did not take account of them. I regret that the Committee was unintentionally misled on this point. The facts are complicated and the Nexos report sets them out in section 10; the letters themselves and the replies are set out in Appendix 10 of the report.

Finally I confirm that there are no parts of the enclosed documents which the Department would like the Committee to treat as being not for publication.

I am sending a copy of this letter to the C&AG with four copies of the papers.

Sir Brian Hayes KCB

20 *June* 1985

MEMORANDUM SUBMITTED BY THE DEPARTMENT OF TRADE AND INDUSTRY

REPORT ON NEXOS (PAC 171)

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9. Letters dated 17 and 18 February 1981 to Sir Keith Joseph from certain Nexos Directors and the replies

1. Termination of Delta Licence

2. Sale of Nexos' Facsimile Business and Stocks

3. Sale of Nexos' Word Processing Business and Stocks

Notes:—

1. In June 1983 the Department of Industry merged with the Department of Trade to become the Department of Trade and Industry. In this Report the Department of Industry and the Department of Trade and Industry are referred to as the "Department" or the "DoI".

2. In September 1981 the National Enterprise Board ("NEB") was combined with the National Research Development Corporation to form the British Technology Group.

3. Nexos comprised a group of seven companies:—

Nexos Office Systems Limited ("NOSL") was the principal company into which the NEB put its money;

Nexos (United Kingdom) Limited ("NUKL"), a wholly-owned subsidiary of NOSL, was the UK sales and service organisation;

Nexos Office Systems (Ireland) Limited, a wholly-owned subsidiary of NOSL, operated a sales organisation in Ireland;

Nexos GmbH, a wholly-owned subsidiary of NOSL, operated a sales organisation in W Germany;

Nexos Leasing Limited was a wholly-owned subsidiary;

Urwick-Nexos Limited was a joint venture between Nexos and the Urwick Orr Group;

Nexos Office Systems Holdings Limited ("NOSH") was the vehicle for a share incentive scheme for five of the senior management of NOSL. The NEB channelled some of its funds through this company which owned part of the share capital of NOSL.

this report Nexos refers to either NOSL or all seven companies, according to the context.

4. Russell Ford is on secondment from Deloitte Haskins & Sells to the Department of rade and Industry's Industrial Development Unit. He was assisted in the investigation by ter Lawrence of the Department's Quality and Education Division.

REPORT ON NEXOS

PART I

1. INTRODUCTION, TERMS OF REFERENCE AND SUMMARY OF MAIN CONCLUSIONS

INTRODUCTION AND TERMS OF REFERENCE

1.1 The Fifteenth Report for the session 1983-84 from the Committee of Public Accounts of the House of Commons, dated 11 April 1984, recommended (in paragraph 32 (vii)) that the Department of Trade and Industry should fully investigate the circumstances of the National Enterprise Board's loss of £31m on its investment in Nexos. The Department accepted this recommendation and I was instructed to carry out an investigation. My terms of reference were

> "To enquire into the circumstances of the loss of £31m on NEB's investment in Nexos".

1.2 I now submit this report having completed my investigation to the extent that I consider necessary.

SUMMARY OF MAIN CONCLUSIONS

1.3 I set out below a summary of my main conclusions, with references to the relevant parts of this report. Paragraphs 1.10 to 1.13 cover the matters raised specifically by the Committee of Public Accounts (" the Committee") in paragraph 28 of its report.

1.4 There were differences between the concept of Nexos approved in September 1978 by the Board of the NEB and the way the plan was subsequently executed. Although the original concept would have been a high risk venture these differences meant that Nexos followed a much higher risk path than the NEB Board originally approved. It is not clear to me to what extent the NEB Board and the NEB's senior executives endorsed the changes or appreciated that Nexos was developing in this way and the matter is partly clouded by changes in the NEB Board and its senior executives in late 1979 and early 1980. (Relevant paragraphs are 4.9-4.12; 4.16-4.38; 4.48-4.49; 5.4-5.21; 5.27-5.30; 12.17-12.20 and 12.23-12.28.)

1.5 The management of Nexos created a much larger organisation, with higher outgoings, than was justified by either the actual level of sales or by the amount of funding approved by the NEB. The management's purpose in so doing appears to have been to obtain the capacity to capture a substantial market share for the first new product they had commissioned, which was the 2200 word processor, as soon as it became available. But this meant that the viability of their business plan became critically dependent on the early market success of the 2200 word processor, which was developed for Nexos by Logica VTS and uproven in the market-place. When the NEB terminated the Nexos venture there appeared to be no immediate prospect of sales reaching the level necessary to cover Nexos' overheads. (Relevant paragraphs are 5.46-5.59; 5.70; 5.76; 5.80-5.81; 5.84 and 5.126.)

1.6 Attention has been focussed on difficulties over the supply of word processing equipment to Nexos by Logica VTS. I believe these difficulties and their impact have been over-stated. Moreover Nexos also encountered difficulties with most of the other equipment it sold or proposed to sell, particularly facsimile machines and the Delta processor. It has been variously said that Logica VTS was late in completing the development of the 2200 word processor, that the product initially lacked a number of necessary features and that it was unreliable in operation. It has been said that these factors caused or contributed to the failure of Nexos. I consider that to the limited extent to which Logica VTS was late, the Nexos management should have recognised and planned for this possibility and that, with one minor exception, the Nexos management knew or should have known that the product was not going to have the features they considered necessary at the time when it lacked them. (Relevant paragraphs are 7.5; 7.11-7.29; 8.20; 9.11-9.14; 9.18; 9.19; 6.5; 6.15 and 6.20.)

1.7 It has also been said that the supply and marketing agreement with Logica VTS was a major factor in the failure of Nexos. Certainly there were a number of difficulties with this

greement. Nevertheless, I do not believe that it was a fundamental cause of the failure of lexos since I do not regard any of these difficulties as having resulted in the failure of lexos. It appears to me that Nexos failed essentially because its management tried to do o much too quickly, having regard to the amount of NEB funding initially committed to . In particular a large organisation was built up, and Nexos effectively committed to a level f expenditure which was out of proportion to the gross profits being earned; this was in ddition to the significant sums being spent on a development programme to develop new roducts. In the event sales never reached the level necessary to cover Nexos' running xpenses. (Relevant paragraphs are 5.48-5.50; 5.54; 5.76; 5.106; 5.110-5.111; 5.126 and .139.)

1.8 It has been said that the Department's decision in February 1981 to consent to urther NEB funding for Nexos was against the advice of its executive directors to Sir Keith oseph, then Secretary of State at the Department. Certain directors did indeed write a tter direct to Sir Keith Joseph in February 1981 in which the view was stated that a merger f Nexos and Logica VTS was a prerequisite to private sector investment without which the ignatories could not recommend further funding given the objective of achieving private ector investment in Nexos. The Department took the view that this was a matter for the NEB and appears to have regarded the letter and an accompanying one from Nexos' nance director as a symptom of management weaknesses at Nexos. (This matter is dealt vith in section 10). Furthermore, the NEB took the view that it did not have the power to nforce a merger with Logica VTS and that there were other courses of action available to eal with problems in the relationship between Nexos and Logica VTS. (Relevant aragraphs are 5.111; 5.112; 5.115 and 5.123).

1.9 Questions have been raised as to the extent of the Department's knowledge of leficiencies in the supply and marketing agreement between Nexos and Logica VTS and vhether the contents of the letter referred to in the preceding paragraph are consistent with vidence given to the Committee previously. A number of distinct but related issues have een alluded to in this context: problems with the supply of product; problems in the vorking relationships between the two companies; deficiencies in the supply and marketing greement; and the reasons for the need for a merger. The Department's first record of the natter is at the end of October 1980 in the NEB's letter requesting consent to increased unding for Nexos. This letter mentioned that Nexos had suffered in its first year of peration from the production difficulties of its major suppliers. An accompanying letter rom the Chairman of the NEB contained a reference to checking that satisfactory progress ad been made in resolving a number of major issues including Nexos' relationship with its uppliers. The letter from certain Nexos directors addressed to Sir Keith Joseph in ebruary 1981 referred to a need to merge with Logica VTS and the accompanying letter eferred to unsatisfactory aspects of Nexos' relationship with that company but it appears nat the Department regarded the letters as a symptom of management weaknesses and neir contents a matter for the NEB to deal with. It was not until May 1981 that the Department received a report from the NEB which referred to the latest Nexos Corporate lan stating that the supply and marketing agreement with Logica VTS was very restrictive. n previous evidence to the Committee the Department stated that it was aware from the utumn of 1980 of supply problems with the products to be marketed by Nexos but it was nly when the NEB became involved in negotiations to dispose of its interests in Nexos that became apparent to the department that these difficulties had their source in the structure f the supply and marketing agreement themselves. (This matter is dealt with in section 1.)

1.10 I now turn to the matters raised by the Committee in its previous report. The ommittee commented on the apparently extraordinary size of the trading losses of Nexos. lowever, the Committee also noted that the figures included setting-up and management osts. The losses arose not only because a business was being started from scratch but also s a consequence of the creation of a larger organisation than was justified. To a great xtent the losses represented the costs of the head office and central management rganisation together with the excess overheads of the sales organisations that were stablished or built up vastly in excess of the size required for the level of the turnover being chieved. I set out in Appendix 3 a summary of where the money put into Nexos went to. his is on a different basis to the figures previously supplied to the Committee but I believe is more meaningful. (Relevant paragraphs are 5.46-5.60; 5.76; 5.81 and Appendix 3).

1.11 The Committee asked whether any consideration was sought in respect of the £5.2 million loss said to have been incurred on R&D. Development costs are set out in Appendix 3, on pages 2 and 5. Except for the 2200 word processor, none of the development projects had come to fruition when Nexos was wound up. In the case of the Delta project consideration was sought but, in accordance with legal advice as to Nexos' obligations under its licence, Nexos' involvement in the Delta project was terminated by negotiation on the basis of no further net cost to Nexos. There were two reasons why no consideration could be obtained from the development work on the 2200 word processor. First, the overall expenses of the word processing business of Nexos were such that the only offer for the business received by the NEB (from Gestetner) required the NEB to invest a substantial further sum: in effect Gestetner's assessment was that the business had negative value. The value of the investment in the development of the 2200 word processor was thus more than off-set by the amounts believed to be necessary to create a viable business. Second, the contractual basis for the development of the word processor meant that Nexos did not have exclusive ownership of the property rights. (Relevant parts are Appendix 11, Appendix 13 and paragraphs 5.149-5.150 and 8.17).

1.12 The Committee also asked why debts of nearly £0.6 million were written off. It appears that most of this amount resulted from the settlement of claims for non-performance by Nexos or its agents and the remainder in settlement of disputes over amounts due to Nexos, including incorrect pricing. Having regard to the outcome of my investigation of Nexos I did not consider that this matter merited the additional time that it would have taken to investigate it in further detail. In my experience, when winding up a business it is not unusual to experience difficulty in collecting residual debts and to find that the potential cost of pursuing them and disputed amounts is likely to exceed the potential recovery.

1.13 Finally, the Committee indicated that they would like to know more about the management deficiencies said to have been a contributory factor to the failure of Nexos. As indicated above, I believe the principal management failing was to embark on a policy that resulted in achievement of the Nexos business plan being critically dependent on the early market success of one product – the new 2200 word processor commissioned from Logica VTS. (paragraphs 5.54 and 5.59). There was a failure to recognise and plan for the possibility of unforeseen delay in a development project of the nature and scale of that of the 2200 (paragraphs 7.7, 7.11 and 7.13 to 7.14). The sales forecasts in Nexos' October 1980 Corporate Plan were based on obtaining 25% of the UK word processor market by the end of the 1981. Yet despite Nexos having agreed the specification for the 2200, after taking a leading part in drawing up the specification in the summer of 1979, Nexos' marketing department concluded in December 1980 that the 2200 was deficient to such an extent that it would not generate the expected revenue (paragraph 7.20 and Appendix 9, paragraph 13). Nexos permitted Logica VTS to proceed with the development of the 2200 when it did not agree with the written proposal from that company for doing so (paragraphs 7.8 to 7.10). Nexos' experience with the Delta project casts doubt on whether, before committing itself to substantial expenditures on the project, it properly assessed the then state of Exxon's project, the nature of the Delta product that Nexos might sell, the market for that product, the timescale for developing a product for Nexos to sell and the cost of such a product development programme (section 6).

2. SCOPE OF ENQUIRIES AND SOURCES OF INFORMATION

2.1 The investigation has been carried out by myself assisted by Mr P H Lawrence of Quality and Education Division.

2.2 Nexos Office Systems Ltd and Nexos (United Kingdom) Ltd are now in liquidation but we have examined their records in the custody of their joint-liquidators. We have also examined records of the Department and NEB.

2.3 In addition we have interviewed the following:—

Mr S J R Dawson – a former NEB staff member and a Director of Nexos.

Mr D A M Dunbar – a former NEB Divisional Director and initial Chairman of Nexos.

Mr P E G Hooton – former Nexos Sales and Marketing Director.

Mr P A B Hughes – Chairman of Logica and a non-executive director of Nexos (accompanied by Mr G Olson – Managing Director of Logica VTS).

Mr D M Moffat – former Nexos Managing Director.

Mr P A C L Oppenheim, MP (accompanied by Mr J Derrick) Co-authors of "What to Buy for Business" magazine article entitled "Nexos – Your Loss".

Dr W P L Wilby – former Nexos Development Director.

Mr J D Wilkinson – former Nexos Finance Director.

Mr W B Willott – a former NEB Secretary and Chief Executive, on secondment from the Department.

2.4 This report is based on information from these sources.

3. SUMMARY OF THE NEXOS VENTURE

Chronology of Main Events in Nexos' Life

September 1978	NEB Board approved proposal to establish Nexos.
January 1979	Agreements with Logica signed. Nexos began operating.
July 1979	First Nexos Corporate Plan approved by NEB.
August 1979	Delphi licence agreement signed.
September 1979	Agreements with Muirhead signed.
October 1979	Nexos acquired Ultronic Data Systems, a sales and service organisation, and commenced trading.
November 1979	NEB Board resigned.
July 1980	Second Nexos Corporate Plan submitted to NEB. NEB decided to undertake major review of Nexos.
October 1980	Review of Nexos considered by NEB. NEB approved funding and sought Secretary of State's consent. 2200 word processor launched (ie sales campaign began).
December 1980	Nexos/NEB told to seek private sector funds. Nexos' cash crisis and beginning of "drip-feed" funding.
January 1981	Sales of the 2200 word processor commenced.
February 1981	Ministers authorised funds to a limit of £35.1m. New non-executive chairman and directors appointed. Executive directors wrote to Sir Keith Joseph.
May 1981	NEB considered new Nexos Plan drawn up under supervision of new non-executive directors. NEB sought direct involvement in management of Nexos and Logica VTS.
September 1981	NEB decided to begin run-down of Nexos and disposal of parts of its business.
November 1981	Delta licence terminated. Agreement in principle announced for Gestetner to take over word processing business.

January 1982 Agreement in principle reached for sale of facsimile business to Muirhead, and sale of 2200 word processor assets to ICL.

A financial and staff profile of Nexos is set out in Appendix 1.

SUMMARY OF THE NEXOS VENTURE

3.1 In 1977 the NEB believed that the UK office equipment market was one of the largest and fastest growing sectors of the UK economy but that, in the absence of an initiative on its part, this market was likely to become dominated by large multinational companies because few UK companies had the technology or capacity to exploit the market for integrated office systems.

3.2 Nexos was conceived and created by the NEB during the period 1977 to 1979 in pursuance of its strategy for the high/medium technology sector of the office equipment market.

3.3 The NEB's basic idea was that Nexos would be primarily a marketing and sales organisation which would work in partnership with a few key suppliers possessing expertise in the technologies required together with production facilities. Nexos' marketing function would enable it to put ideas for new products to these suppliers who would be responsible for developing the ideas into new products. Nexos' role in this area would be to co-ordinate the development of an integrated range of products.

3.4 The NEB intended Nexos to start by taking over the selling of existing office equipment products of Logica and Muirhead together with the existing sales and support organisations for those products and build on this base, progressing via development projects to selling an integrated product range. Agreements with the Muirhead group and the Logica group which were fundamental to the NEB's concept were negotiated and concluded by the NEB.

3.5 To put their concept into practice the NEB recruited a managing director for Nexos at the beginning of 1979 and, together with him, a management team. The NEB discussed its strategy and the concept with initial members of the team as part of the recruitment process but gave the Nexos management considerable freedom as to how they put the concept into practice. The Nexos management had its own ideas on how to best attain the NEB's objectives, especially as regards the marketability of the existing Logica and Muirhead office equipment products and the systems architecture for and development route to an integrated office system.

3.6 Under the Nexos management there was an immediate shift in emphasis and from the outset it concentrated on the development functions. A development director was recruited and he became one of Nexos' four executive directors. His department grew to some 30 people. Although there is little hard evidence that the shift in emphasis was recognised and approved by the NEB it does appear that the NEB were aware of it and endorsed it.

3.7 The Nexos management had their own ideas on how to create integrated office systems and where to go to acquire the necessary technologies for the component parts of these systems. They neither wished to be tied exclusively to the two companies initially chosen by the NEB (Logica and Muirhead) nor to the outline product development plan envisaged by the NEB.

3.8 Their basic approach was to develop from scratch a number of new products and at the same time to build very rapidly a large sales and marketing organisation so that it would be ready when the first of those products became available to sell.

3.9 Nexos commissioned a number of feasibility and design studies and development projects. In the case of the Delta project it even undertook development work itself. The planned Delta machine was intended eventually to be the core-piece of Nexo's integrated office system. In 2 years over £2½m was spent on the Delta project but no saleable product ever emerged despite an initial forecast by Nexos that Delta sales would commence within 16 months.

3.10 A completely new word processor was commissioned by Nexos from Logica VTS which that company was allowed to start developing without full agreement by Nexos to Logica VTS's proposed Development Plan. This subsequently led to financial disputes.

3.11 Having commissioned the development of the new word processor from Logica VTS, Nexos embarked on building a sales and back-up service/maintenance organisation. As a base, Nexos acquired in October 1979 a small sales and maintenance company and expanded its staff far beyond the level justified by its turnover. Nexos' intention was to have built one of the biggest sales and service organisations in the UK word processor market by the time the new word processor was available to sell. This was a very high risk policy. First, Nexos would have to bear the cost of this organisation until such time as the new word processor could be delivered to customers in volume. Second, the sales organisation would continue to make a loss if sales of the new word processor, which was not proven in the market place, did not quickly achieve sufficient volume to cover the organisation's operating costs.

3.12 The former managing director, finance director and sales and marketing director of Nexos have stressed to us that this policy, and the inherent risks, were known to and approved by the NEB. This was true of the NEB staff member who was monitoring Nexos. However, it is not clear to what extent senior executives, financial executives or the NEB Board were aware of this policy or the risks inherent in it. We have found no evidence that they were so aware but the matter is clouded by changes in the NEB Board and its senior executives in late 1979 and early 1980.

3.13 From a standing start in 1979, within eighteen months an organisation was built whose overhead and development expenditure was running at an annual rate of £15m.

3.14 In October 1980 when the NEB considered the results of an independent review of Nexos the options open to it were limited. To have stopped funding would have resulted in the immediate cessation of operations at Nexos and the NEB would have lost its investment. The review team concluded that Nexos' product strategy and the products so far defined were competitive; that the planned rate of return to the NEB was high; but that Nexos had set itself ambitious targets and its business plan carried substantial risks. The plan was critically dependent on the success in 1981 of the new word processor developed by Logica VTS then on the point of being introduced to the market. In the medium term, Delta was seen as offering the possibility of Nexos obtaining a substantial share of the office systems market. The NEB recognised the substantial risks but decided, having regard to its special statutory objectives, to approve further funding for Nexos.

3.15 Before consenting to further NEB funding the Department put pressure on the NEB and Nexos to obtain a private sector partner for Nexos. However, the resultant delay caused a financial crisis at Nexos since by December 1980 Nexos had consumed the funds previously authorised.

3.16 The financial crisis caused serious damage to Nexos, particularly its credibility in the market place, and management and staff morale and, probably, in the attitude of key suppliers. Having regard to this and the likelihood that if funding stopped nothing could have been salvaged from the existing investment Ministers reluctantly consented in February 1981 to further funding subject to a number of conditions.

3.17 In the event sales of the new word processor never achieved the volumes forecast by Nexos nor the level necessary to make an acceptable contribution to on-going costs. None of the other new product developments had come to fruition by September 1981 when the NEB decided to run down the business of Nexos whilst still trying to arrange a disposal of the word processing activities to Gestetner.

3.18 Agreement in principle was reached with Gestetner on a deal which would have involved the investment of a substantial further sum by the NEB. However, before contract negotiations had been concluded ICL made a proposal for a more straightforward purchase of the word processor assets of Nexos. This proposal was preferred by Logica and was financially better for the NEB and in January 1982 agreement was reached whereby ICL

acquired Nexos' stocks of the new word processor. Its other activities were either disposed of as going concerns or closed down prior to putting Nexos into liquidation.

3.19 The latest estimate of the NEB's loss on Nexos is £24.2m, as set out in Appendix 2. This amount takes into account the tax saved by the NEB and its subsidiaries, estimated at £7.652m, from the utilisation of Nexos' tax losses.

Part II

4. BACKGROUND TO THE ESTABLISHMENT OF NEXOS

4.1 Nexos was conceived and created by the NEB in pursuance of its strategy for the high/medium technology sector of the office equipment market. This section outlines the background to the formation of Nexos and the NEB's concept of Nexos.

Powers of the NEB and its Supervision by the Department

4.2 As the story of Nexos starts with the NEB I have considered the powers of the NEB and the arrangements then in force for its supervision by the Department. Details of these matters are set-out in Appendix 4. In summary, it appears to me that the NEB was given a large measure of operational and commercial freedom and that supervision of the NEB was intended to be by means of annual review of its corporate plans. I have satisfied myself that, with regard to the establishment of Nexos and its funding, all necessary consents were requested and given and directions complied with.

NEB Corporate Plan 1977-81

4.3 The NEB's Corporate Plan for 1977-81 identified the Office Equipment Sector as requiring an initiative by the NEB for the following reasons:—

(*a*) The Office Equipment market was one of the largest and fastest growing sectors of the UK economy;

(*b*) UK companies had dropped out of key segments of the market and the UK market was becoming increasingly dominated by extremely large multinationals;

(*c*) Few of the remaining UK companies had either the technology or the capacity to exploit the market for "The Integrated Office of the Future".

For the record, details of the Plan, its review by the Department and approval by the Secretary of State are set out in Appendix 5.

4.4 The Plan stated that detailed plans for the Office Equipment Sector were being prepared and that a decision had been taken to concentrate on four distinct market areas one of which was the "Integrated Office of the Future".

NEB Strategy for the Medium/High Technology Segment of the Office Equipment Market

4.5 The NEB was divided organisationally into a number of divisions one of which was the Computers and Electronics Division. This division, known as Division B, was headed by one of the NEB's Divisional Directors, Mr D A M Dunbar.

4.6 Mr Dunbar told us that the task of looking at the "Office of the Future" was given to Mr S J R Dawson, who was one of the staff of the Division. He said that Mr Dawson had developed the concept of Nexos in discussion with various companies in the industry.

4.7 Discussions between the NEB and Muirhead Ltd started in the summer of 1977 and, initially, the Nexos idea appears to have been based on a joint company with Muirhead.

4.8 Following on from the NEB 1977-81 Corporate Plan, a Paper, stated to have been written by Mr Dunbar, recommending a strategy for the medium/high technology segment

of the office equipment industry was considered and approved by the NEB Board in April 1978. The stated reasons for the proposed strategy may be summarised as follows:—

(*a*) the medium/high technology segment was expected to move towards individual products becoming interconnectable in an integrated office system.

(*b*) the UK was unlikely to obtain any significant share in this sector of the office systems market because none of the dozen plus UK companies with a capability in this part of this market was an international force in more than one of the required technology/market areas.

(*c*) this would be a missed opportunity and have an adverse effect on the balance of payments—approaching £1bn by the mid 1980s. (The Paper did not state whether the £1bn was pa or cumulative.)

4.9 Accordingly the Paper recommended a two pronged strategy for the NEB in this field:—

(*a*) The NEB would make equity investments in individual UK companies which, with NEB support, could develop and produce the key "building blocks" for the office systems of the future;

(*b*) The NEB would establish a new company (subsequently called Nexos):—

(i) to take over and substantially expand the sales and marketing operations of these building block companies (including their then current product ranges);

(ii) to assume responsibility for linking together the products of those various companies into systems which would meet the varying requirements of individual customers;

(iii) to co-ordinate, and if necessary to fund, the development of a compatible product range for the office sytem of the 1980s.

4.10 The proposal was to start off with a word processor and "facsimile/copier/printers" and to examine other possible products, giving high priority to a message switch device/ EPABX, to high performance printing systems and to information storage and retrieval products.

4.11 It was envisaged that the word processor would be developed by Logica and the "facsimile/copier/printers" would be developed by Muirhead and that proposals would shortly be put to the NEB Board for equity investments to be made by the NEB in Logica's word processing business and Muirhead's office facsimile machine business.

4.12 The intention was that Nexos would start life with a base of existing products and progress via development projects to marketing an integrated product range.

Proposed NEB Investment in Logica

4.13 Subsequently, in May 1978, the Board of the NEB considered and approved a Paper proposing an investment in Logica. The proposed investment appears to have been as part of arrangements to bring Logica into the INSAC consortium but another attraction was in obtaining Logica as a supplier of its word processor for Nexos.

4.14 The NEB had recently created a marketing organisation called INSAC to exploit the UK's software skills overseas. INSAC consisted of the INSAC consortium together with INSAC Data Systems Ltd, which was an NEB subsidiary formed to market abroad software produced by member companies of the INSAC consortium. The consortium had been formed by the NEB who generally took a large minority shareholding in member companies.

DoI Approval of Investment in Logica

4.15 The NEB then wrote to the Department seeking approval, pursuant to Section 10, Industry Act 1975, for its proposed investment in Logica. Its letter recalled the 1977-81 Corporate Plan, referred to the Strategy Paper approved by the Board in April and gave a summary of the main points of the Strategy Paper without providing quantitative information on turnover, profit or rate of return. The letter said that the NEB would return

to the Department in due course with a specific proposal for the office systems company (Nexos) but a qualitative description of the office systems strategy was given to set the context for the proposed Logica investment. Consent was given for the Logica investment in June 1978, the proposal having been cleared with Ministers.

PROPOSAL TO ESTABLISH NEXOS

The September 1978 Board Paper

4.16 The specific proposal to establish Nexos was put to the NEB Board in September 1978 in a Paper stated to have been written by Division B. The intention was to put into practice the strategy already approved by the Board the previous April.

4.17 The proposal was that the NEB would set up from scratch a company (subsequently called Nexos) to take over the marketing and support of existing products, and to co-ordinate, and where necessary fund, the development of an integrated range of products for "the electronic office". Existing suppliers would be responsible for the production and development of products in specific categories. Already earmarked were Logica, who it was intended would set up a new subsidiary, Logica VTS Ltd, to take over its word processing business, and Muirhead, who the NEB proposed should establish Muirhead Office Systems Ltd ("MOSL") for its office facsimile machine business.

4.18 The Paper stated that in addition to Logica VTS and MOSL, the NEB had investments in several other companies that could provide valuable products or skills for Nexos, particularly CASE (message switching), Systime (office data processing), DRI (storage and printing devices), INSAC and INSAC members (software and system skills and Viewdata expertise) and Monotype (high quality printing).

4.19 The Paper stated that Nexos would take over the marketing of Logica's existing word processor products and Muirhead's existing office facsimile terminals and reiterated that Nexos would be taking over the marketing of existing products already being produced and sold by established groups.

4.20 Starting from a base of existing word processing and office facsimile products, the main development projects were seen to be development of the existing word processor, new facsimile products, Wordfax (a system for the transmission of mixed text and images), new printer, intelligent copier, storage/retrieval system interfacing, data processing interfacing and electronic PABX/message switch interfacing.

4.21 The Paper gave a five year projection of development costs for these and other developments which totalled £19.35m of which £4.15m might be borne by Logica VTS and MOSL, leaving Nexos to find £15.2m over five years.

4.22 The Paper also gave a five year projection of turnover, gross profit, overheads and increases in working capital. Based on these projections, it gave a five year projection of cash flows for Nexos. These projections may be summarised as follows:—

15 *July* 1985] [*Continued*

K	1979	1980	1981	1982	1983	TOTAL
Turnover–						
- existing and new facsimile products	5,100	9,500	14,400	17,800	21,000	67,800
- existing and new word processing products	3,500	8,000	13,500	20,000	30,000	75,000
- other new types of product	—	—	3,000	10,000	30,000	43,000
	8,600	17,500	30,900	47,800	81,000	185,800
Gross profit thereon	2,200	4,700	9,000	15,400	28,200	59,500
Overheads excluding depreciation	2,400	3,850	5,800	7,950	13,200	33,200
Trading (loss)/surplus before depreciation	(200)	850	3,200	7,450	15,000	26,300
Increase in working capital	2,600	2,250	3,000	5,050	6,700	19,600
Cash (outflow)/inflow resulting from trading activities	(2,800)	(1,400)	200	2,400	8,300	6,700
Capital expenditure	600	1,200	1,800	2,400	3,000	9,000
Development expenditure (net of amounts borne by MOSL and Logica VTS)	1,000	1,700	2,200	3,600	6,700	15,200
Cash outflow from all operations	4,400	4,300	3,800	3,600	1,400	17,500
Interest on loan finance	—	—	—	300	700	1,000
Total cash required	4,400	4,300	3,800	3,900	2,100	18,500
To be provided as follows:–						
- By the NEB in the form of capital and loans	4,500	4,250	3,750	2,000	500	15,000
- By bank borrowing by Nexos	(100)	50	50	1,900	1,600	3,500
	4,400	4,300	3,800	3,900	2,100	18,500

4.23 The Paper estimated that the products to be taken from Muirhead and Logica would generate turnover of £3½m in 1978, achieving a break-even position. The summary of the Paper pointed out that the first year's forecasts showed sales of £8.6m and a loss of £1.3m (after depreciation and development expenses).

4.24 The Paper stated that there was a high level of confidence in the sales forecasts for the first two years.

4.25 The Paper gave no information on how the sales forecasts had been arrived at, although it did show the UK and European market shares for facsimile and word processing that the sales forecasts represented. Neither did it show funding requirements on the basis of alternative scenarios; such as different rates of turnover growth, rates of gross margin or development costs.

4.26 In the light of Nexos actual experience, I have examined NEB records in an attempt to establish the basis for the various figures which appear in the Paper, particularly the sales and market projections and development expenditure projections. Although I have found a number of manuscript records of calculations leading up to the figures in the Paper I have found no documentation showing their source, how the figures were arrived at or the basis on which they were forecast, nor any sensitivity analysis of them.

4.27 Mr Dunbar told us that the forecasts and projections would have been put together in discussions by Mr Dawson with Logica and with Muirhead. He said that the initial sales projections for Nexos had been compiled by looking at the existing sales of Muirhead and Logica VTS and increasing them to take account of the additional market weight that Nexos would give.

4.28 The forecasts showed that, except by a small margin in the first year of operation, the overheads (excluding development expenditure) were expected to be covered by the gross profit from trading operations. Even allowing for the increase in working capital resulting from the fast growth in turnover projected, trading activities were forecast to generate cash, before capital and development expenditure, by the third year of operation.

4.29 The cash flow forecast showed a total cash requirement for the first five years of £18.5m. However, the Paper only proposed committing £15m of NEB funds towards this requirement and effectively assumed that by 1982 Nexos would have become sufficiently established as a going concern to be able to obtain bank credit rising to £3.5m by the end of 1983.

4.30 The Paper stated that the April 1978 Office Systems Strategy paper envisaged total investment in Nexos of approaching £40m over a five year period in addition to the cost of NEB investments in its suppliers.

4.31 The Paper proposed that Nexos be formed as a 100% subsidiary of the NEB with a firm commitment of £12m in equity finance and £3m in loan finance and that the remaining £25m be taken into account in the NEB's financial planning, and be committed subject to Board approval of specific proposals for expanding the scope of Nexos. The Paper stated that Nexos would not obtain the funds allocated until people of the right calibre had been found to fill the key positions in the management team.

4.32 The Paper stated that the return on NEB capital employed was expected to reach 32% by 1983.

4.33 The risk factors listed in the Paper were the required strength of the management team and their ability to cope with the projected rates of growth; the viability of the proposed corporate structure, particularly the relationships with suppliers; and the availability of additional products. Discussion of the relationship with suppliers suggested that their dependence on Nexos as a sales outlet plus the NEB's equity stakes (which might be transferred to Nexos at a later date) would give Nexos sufficient control. Nexos would also have access to detailed financial and production information. The Paper stated that in the unlikely event that one of the suppliers could not produce the next generation of products, Nexos could move to another supplier with little disruption and with acceptable costs.

4.34 Finally, the Paper suggested that the main features of the agreements with Nexos' suppliers would be:—

- mutual exclusivity on existing products;
- provision for either party to withdraw only in the event of extreme failure of the other party to perform;
- negotiated transfer prices to reflect risks to each party;
- full exchange of information as though both parties were part of a single company;
- co-operation on development, with Nexos providing funds in exchange for advantageous marketing terms.

scussion and Approval of the Paper

4.35 The Paper was presented to the NEB Board by Mr Dunbar, and the minutes record at he said that discussions with Logica and Muirhead had reached the stage where the ancial and operational terms were settled.

4.36 The Chairman told the Board that it might have been preferable to delay seeking e Board's approval until the key appointments had been fixed, but he had accepted the w that a declaration of intent by the Board would strengthen the NEB's hand in securing od people.

4.37 The following were among the points made in discussion:—

— the costs looked high for a marketing company, but much of the initial expenditure related to the setting-up of offices overseas and to R&D;

— mutual interdependence of Nexos and its suppliers was not ideal, but was the closest the UK could get to the single company capability of major companies like IBM;

— the question of transfer prices would be crucial, and the agreements with supplier companies would provide for specific prices for existing products and an agreed framework for future products.

ıe paper gives the impression that Nexos would be starting with a well established siness base. It is not apparent whether the Board were aware that the first commercial le of Logica's existing word processor, the VTS 100, had taken place only three months eviously in June 1978. If not, I cannot judge whether knowledge of this fact would have fluenced the Board's decision.

4.38 The NEB Board approved the proposals, as set out in the Paper. In approving the oposals, it noted the high risks involved and emphasised the importance of securing a ief Executive of very high calibre, especially in the marketing field.

oI Approval of Nexos Proposal

4.39 Subsequently the NEB requested approval, pursuant to Section 10, Industry Act 75, for the proposed establishment and initial £15m funding of Nexos and this approval as given in November 1978. For the record, background information on the approval is ven in Appendix 6.

greements with Logica

4.40 The NEB continued negotiations with both Muirhead and Logica. In the case of ogica negotiations were concluded and a series of agreements signed in January 1979. owever, in the case of Muirhead problems emerged and it was not until September 1979 at negotiations were concluded and the agreements signed.

4.41 The objects of the agreements with Logica were to bring Logica into the INSAC nsortium and to give Nexos the exclusive right to sell Logica's VTS 100 word processor. ıe actual agreements are highly complex but, in summary, I understand their effect to ve been that:—

(*a*) Logica's previous American majority shareholder was bought-out with NEB money;

(*b*) a new holding company for the Logica group, called Logica Securities Ltd, was established with two new partly owned subsidiaries, Logica VTS Ltd (57% owned) and Logica Holdings Ltd;

(*c*) Logica's principal software business remained in several UK and overseas companies which became subsidiaries of Logica Holdings;

(*d*) Logica's word processing activities were transferred to Logica VTS, which then received an equity injection by the NEB of £500,000;

(*e*) management and employees of the Logica group became the owners of 80% of Logica Securities;

(*f*) the NEB became the owner of the remaining 20% of Logica Securities, 43% (effectively) of Logica VTS and, ultimately, 20.8% of Logica Holdings;

(*g*) the management and employee shareholders in Logica Securities were given a 'put' option entitling them to sell a part of their individual shareholdings to the NEB at stated periods in the six years to 1984. The price to be equal to ten times the consolidated net profit per share of Logica Securities and its subsidiaries for its financial year preceeding exercise of the option;

(*h*) a Supply and Marketing Agreement ("S&MA") was concluded between Logica VTS and Nexos giving Nexos exclusive rights to sell the VTS 100, and providing for a number of other matters relevant to their future relationship.

(*i*) a long term loan facility of £750,000 was made available by the NEB to Logica VTS;

(*j*) Memoranda of Understanding between the Neb and Logica Holdings and Logica VTS provided for financial returns to be made on a monthly basis to the NEB; for annual mutual agreement of plans and budgets; and stated that the NEB would not intervene in the day-to-day management of the companies.

4.42 Mr P A B Hughes, Chairman of Logica, was subsequently appointed a non-executive director of Nexos, a position he continued to occupy until October 1981.

4.43 Mr Moffat told us that, much later, he became aware of the possibility that Logica shareholders had an option to 'put' shares of Logica VTS on NEB at a price of ten times the earnings of Logica VTS but this was never confirmed to him. He was concerned that such an option could have provided a motive for Logica to bleed as much money as possible from Nexos into Logica VTS via the S&MA. This appears to be a reference to the option agreement in paragraph 4.41 (g) above which related to shares in Logica Securities and was at a price of ten times the consolidated earnings of that company. I have calculated that under this agreement the Logica management and employee shareholders, as a group, stood to gain an additional 82% of the amount by which they could increase the profit of Logica VTS in financial year *provided* they exercised their option to sell *all* their shares subject to the option to the NEB immediately following that financial year. Details of this calculation are set out in Appendix 7.

4.44 This appendix also shows the profit contribution of Logica VTS to Logica Securities for each of the two years ended 30 June 1981, from which it can be seen that the profit contribution of Logica VTS to Logica Securities as a whole was relatively small. I am therefore inclined to the view that any motive to "milk" Nexos would have been weak.

4.45 The effect of the S&MA with Logica VTS, which was drafted by solicitors acting on behalf of the two parties, was that:—

(*a*) Logica VTS gave up to Nexos the right to sell its existing stand-alone word processor, the VTS 100. Thus any future profit between the cost of manufacture and the selling price to end users had to be shared between Logica VTS and Nexos;

(*b*) Logica VTS effectively had first option on carrying out Nexos development projects in the field of word processing;

(*c*) In respect of development projects commissioned by Nexos in the first two years, all the development risk was borne by Nexos as it had to reimburse Logica VTS at cost plus a commercial profit margin to be agreed between them. The terms of subsequent development contracts were negotiable;

(*d*) Logica VTS was left free to develop whatever products it wished but Nexos had first option over the sole and exclusive worldwide marketing rights;

(*e*) Marketing risks on products developed for Nexos were to some extent shared between the two companies but Logica VTS was shielded by the transfer price formula from making a loss on their manufacture.

(*f*) Nexos was obligated to bear the following expenses of Logica VTS during the first two years:—

(i) non-recurring expenses of a non-capital nature in establishing production facilities

(ii) excess expenses incurred in establishing production facilities with a greater capacity than justified by initial production levels of Logica VTS

(iii) costs of staff recruited by Logica VTS on behalf of and at the request of Nexos

(iv) research and development costs of the VTS 100.

(*g*) The agreement was for 50 years and could only be broken within that period by:—

— mutual agreement after the first two years

— substantial breach of its obligations, failure to perform, insolvency or change in control of one of the parties.

4.46 Mr Dunbar told us that Nexos' S&MAs with both Logica and Muirhead were gotiated by Mr Dawson although, as the Head of Division B, Mr Dunbar would have proved the agreements reached. With regard to the Logica VTS S&MA, Mr Dawson ld us that this had been negotiated by himself and Mr Dunbar.

4.47 Mr Hughes told us that the S&MA had not been one that Logica themselves were rticularly happy with and that, when negotiating it, they had nearly broken off scussions with the NEB over its contents. But at the end of the day they had signed up cause the overall value of the arrangement to Logica was such that it made it worthwhile ing ahead.

4.48 There is a difference between the basis on which the NEB Board approved the tablishment of Nexos and the terms of the S&MA entered into with Logica VTS. This fference, regarding transfer prices, caused disputes between Nexos and Logica VTS but I not consider them to have been the cause of Nexos' failure. The NEB minutes recording Board's approval in September 1978 of the proposal to establish Nexos record that, in scussion, the NEB executives stated that the agreements with supplier companies would ovide for specific prices for existing products and establish an agreed pricing framework r future products. The S&MA with Logica VTS does not satisfy these conditions. ansfer prices for both existing and future products were based on the cost to Logica VTS their manufacture (whatever this turned out to be) and merely stipulated upper and wer ends of the range of mark-up within which Nexos and Logica VTS were left to agree ices at six or twelve monthly intervals.

4.49 I have found no indication that this difference was reported to the NEB Board by its aff for ratification.

4.50 As indicated above, development work in the first two years of the S&MA was to be dertaken at cost plus a commercial profit margin to be agreed between Logica VTS and EXOS. However, the S&MA did not provide for how cost was to be ascertained when gica Holdings provided the services of its staff to Logica VTS; in particular, whether gica Holdings was to be regarded as an arms length supplier of services or whether ost" was to be taken as cost to Logica Holdings.

4.51 Mr Dawson told us that he did not recall the point being discussed in the gotiations. He thought that those involved had probably imagined that the split of nctions between the two parts of the Logica group would be neater than it subsequently rned out to be. He felt that the problems subsequently cause by this omission from the &MA could have been overcome had there been a better working relationship between e various parties. He also told us that there was a considerable benefit to Nexos in Logica TS being able to draft in Logica Holdings experts for specific tasks.

4.52 In my view, the S&MA was not the root cause of the failure of Nexos. The failure, stly, to recognise that development work would necessitate the use of staff employed by gica Holdings (as opposed to staff employed by Logica VTS) and, secondly, to make ecific provision for transfer prices did result in a long running dispute between the two mpanies. However, I do not believe this dispute caused the failure of Nexos and the sultant loss to the NEB. It is possible, however, that had Nexos not failed in other ways, e structure of the S&MA would have been an obstacle to a successful transfer of Nexos to e private sector. But when the proposal to establish Nexos was approved by the NEB ard in September 1978 there does not appear to have been any intention eventually to ansfer Nexos to the private sector; furthermore, at that time, one of the functions of the EB was extending public ownership into profitable areas of manufacturing industry.

Recruitment of Nexos Managing Director

4.53 In mid-1978 the NEB engaged a firm of "head-hunters" to recruit a managin director for Nexos. Mr Dunbar told us that he spent some time personally briefing th head-hunters on the search for a suitable managing director. He also spent a considerabl time discussing the Nexos concept with Mr D M Moffat who was the person subsequentl recruited by the NEB as the Nexos Managing Director. Mr Dunbar said that in terms c personal qualities Mr Moffat was well ahead of the other names given to him by th head-hunters and had in many ways the ideal background in information systems. M Moffat came from IBM where he had spent 13 years in sales and marketing. He joined th NEB in mid-January 1979, a few days before the NEB's press announcement of th formation of Nexos and of its agreements with Logica.

NEB Brief to Nexos Managing Director

4.54 Mr Dunbar told us that Mr Moffat was shown a copy of the Paper approved by th NEB Board in September 1978 which set out the proposal to establish Nexos and put int practice the NEB's strategy for the medium/high technology segment of the offic equipment industry. Also that he and Mr Moffat had a number of conversations about th role and rationale for the NEB and it was up to the newly recruited management to wor out the details of the business plan.

4.55 Mr Moffat confirmed to us that apart from the September 1978 NEB Board Pape he was not given a written brief or business plan. He told us that he regarded his brief to be to build a marketing led office *systems* company which would grow as fast as possible; t become large enough in the short time window perceived to be available to survive as a independent British company; to have initial funding of £15m and a recognition that up t £50m (in 1978 money) might be necessary; and to start on the basis of the Logica an Muirhead agreements negotiated by the NEB.

5. HISTORY OF NEXOS

5.1 This section outlines the history of Nexos until its winding-down. Only brie reference is made to certain topics which are more appropriately dealt with in separat sections. These are the Delta development, the basis and timetable for the development b Logica VTS of the 2200 word processor, the relationship with Logica VTS, and th relationship with Muirhead. Appendix 1, which gives a financial and staff profile of Nexos should be referred to for a preliminary appreciation of Nexos.

The first six months of Nexos

5.2 During the first half of 1979 about half a dozen staff joined Nexos, during which tim the newly formed company established offices in Hay Hill, London. The only executiv director in this period was Mr Moffat.

5.3 In May 1979 the General Election resulted in a new Government. Mr Dunbar wa the non-executive Chairman of Nexos until he left the NEB in October 1979.

Decision not to Take over the Selling of the VTS 100

5.4 Mr Dunbar told us that initial attention was concentrated on getting an operatin relationship going with Logica VTS. He said that the priorities were to recruit technica people, to get the supply agreements working and the sales force built up. He said that i turned out that the VTS 100 was not as ready for the market as the NEB had been led t believe. The situation was compounded by uncertainty due to the Nexos team bein unhappy about the physical appearance of the VTS 100 and suggesting design changes.

5.5 Mr Dawson told us that, with hindsight, he thought it might be the case that the VT 100 was not as saleable as they had thought, and when the Nexos management tea brought their experience to bear on it, it became evident that if Nexos was to achieve it objective of becoming the UK market leader, the product would need re-engineering fo volume production, and a number of additional features.

5.6 It is clear to us from Nexos' records dating from the first half of 1979 that Mr Moffa and his assistants were not happy with the VTS 100 as a product and did not believe Nexo

uld sell it in substantial volumes. Mr Moffat told us that at the time he joined Nexos the TS 100 had only just been developed and Logica were not really selling it. He also told us at he and an assistant quickly formed the view by February that the VTS 100 was adequate for the market and accordingly decided that Nexos needed a more advanced ord processor. They considered that, although the software design was good as a basis for evelopment, it required many additional functions, the hardware was too expensive and e overall design was not ergonomic.

5.7 Mr Moffat decided that, since it was considered the existing VTS 100 could not be ld by Nexos in substantial quantities, priority should be given to the development of a ew word processor based on the VTS 100, with the aim of selling modest quantities of the isting VTS 100 until the new machine became available. The development of the new ord processor (which became known as the 2200) is dealt with separately in Section 7.

5.8 Meanwhile the possibility arose of acquiring an office equipment sales and aintenance company, Ultronic Data Systems Ltd ("UDS"), and discussions began which d to its purchase by Nexos in October 1979. In the light of these discussions, Mr Moffat ecided that it was not worthwhile for Nexos to attempt to sell the VTS 100 in advance of quiring UDS. Therefore, Nexos did not take over selling the VTS 100 or any of the sales nd support staff of Logica VTS. It was February 1980 before Nexos commenced selling the TS 100 having taken over the relevant Logica VTS staff that month.

5.9 Mr Hughes told us that Logica tried hard to persuade Nexos to pick up and sell the TS 100. Logica were concerned that otherwise their existing customer base would be ssipated. He said Nexos were reluctant to start business with "old" products and its anagement felt they wanted a new product. He also told us that although the VTS 100 had s limitations and was expensive to produce, because it had never been engineered for olume production, he believed there was nevertheless a demand for it.

roposal to Acquire UDS

5.10 The NEB had run into problems in its negotiations with Muirhead and so Mr loffat and his assistants could not make any firm arrangements to take over the selling of luirhead's office facsimile products.

5.11 Mr Moffat told us that the Nexos management faced a dilemma at this stage: they ould not recruit a sales force because they felt they had no saleable product. Accordingly ey had to manage the development and recruitment programmes in parallel so that the roducts and sales force appeared at the same time. As well as a sales force, Nexos needed have a field engineering force to provide the necessary service back-up. As a short-cut to is objective the acquisition of UDS was negotiated by Nexos.

5.12 UDS had about 100 staff and distributed some office equipment products in the UK acked up by a service and maintenance organisation. Its principal product was the Ricoh C" text, a single line display word processor imported from Japan. Mr Moffat said that ne specifice advantage was that UDS had the distributorship of a daisywheel printer anufactured by Ricoh. This was a good machine of a type that Nexos would in any case eed to import from either the US or Japan as part of its system.

elta

5.13 In February 1979 the NEB introduced Mr Moffat to the Delphi Communications orporation ("Delphi"), a Californian based associate of the Exxon Oil Group, and to its elta processor. This led to Nexos becoming involved in the Delta project. I consider this roject to be an important part of the Nexos story because of its overall cost, Nexos' anging perception of Delta and because in over 2 years no saleable product ever emerged om the project despite an initial forecast that sales would commence in late 1980. herefore I given an outline of Nexos' involvement with Delta separetely in section 6.

HE JULY 1979 NEXOS CORPORATE PLAN

5.14 The first six months of Nexos culminated in the July 1979 Nexos Corporate Plan eing submitted to the NEB for its approval. This was the first corporate plan prepared by

the management of Nexos (as distinct from the NEB), although at that time the only executive director was the managing director, Mr Moffat; the development, sales and marketing and finance directors had not yet joined Nexos.

Contents

5.15 The Corporate Plan stated that, although it superseded the plans for Nexos as set out in the NEB's April 1978 Office Systems Strategy Paper and September 1978 Paper proposing the establishment of Nexos, it was consistent with the previous strategy. It set out plans for Nexos' business and included financial projections for the six years 1979 to 1984.

5.16 Three appendices dealt in more detail with the three main proposals by Nexos:—

(*a*) the licence of the Delta communications management computer from Delphi;

(*b*) the acquisition of UDS;

(*c*) the setting up of an office systems education company (Urwick-Nexos) as a joint venture with Urwick Orr.

5.17 The body of the Corporate Plan appears to be an attempt to reconcile the plans of Mr Moffat and his assistants, which centre on Delta, with the original proposals put to the NEB Board. Of the situation with Logica it said "Logica VTS sales were initially affected by the uncertainty over transferring marketing of its products to Nexos. Otherwise the relationship is progressing well." Later it stated "There has been a greater than expected hiatus in word processing sales by Logica VTS .....". The Plan did not state that Nexos was planning to sell hardly any Logica VTS products in 1979. Of the relationship with Muirhead it stated, correctly, that the agreements were near to completion after considerable delay and cautioned that "The facsimile market is developing more slowly than most forecasts were predicting a year ago ...".

5.18 A cash flow summary for the six years 1979 to 1984 showed a net outflow of cash in the five years to 1983 amounting to £26.877m. It was proposed that £20m should be provided by the NEB leaving £6.877m to be obtained by bank borrowing on the apparent assumption that by 1981 Nexos would have become sufficiently established as a going concern to be able to obtain bank credit rising to £6.877m by the end of 1983.

5.19 The NEB return on capital employed up to 1983 was stated to be lower than that previously planned but still adequate and rising from 16% in 1982 to 46% in 1984.

Approval by the NEB

5.20 At its July 1979 meeting the NEB Board was asked to approve Nexos' Corporate Plan. It was given a Paper comprising the notes of a meeting between Division B staff and Nexos management to review the Corporate Plan (the NEB's Executive Review). The Corporate Plan document itself was not given to Board members (with the possible exception of the two executive members) but we have been told by the Secretary of the NEB that it would have been available to any member wishing to see it.

5.21 The July 1979 Nexos' Corporate Plan was approved by the NEB Board at its July meeting and in so doing the Board specifically approved the proposals to acquire UDS and to enter into a licence agreement with Delphi. The Board also approved an additional NEB investment in Nexos of £5m (taking the total investment so approved to £20m), but left to the NEB Chairman the timing of the approach to the Secretary of State for statutory consent. The approval of the proposed UDS acquisition and Delta licence effectively approved proposals to import foreign manufactured products.

NEB and DoI Attitude to Imported Products

5.22 There has been criticism that, given the reasons for setting up Nexos, it was allowed to import foreign products. Through UDS it imported and sold Japanese Ricoh printers and word processors, through MOSL it subsequently imported Japanese Oki facsimile machines, and it proposed to import the Delta communications management computer from the United States until it could establish a manufacturing source in the UK. In fairness

should be pointed out that UDS was already importing the Ricoh equipment and its quisition by Nexos changed nothing.

5.23 I have looked at documentary records indicating the views of the NEB and the epartment on this issue at the time the UDS acquisition and the Delta licence were proved. These views are summarised in Appendix 8. It appears that it was recognised at the Nexos management were proposing to import foreign equipment but, for various asons, this was accepted by the NEB and the Department.

HE SECOND HALF OF 1979

5.24 In the second half of 1979 Nexos:—

(*a*) licensed the Delta technology;

(*b*) was joined by its finance director and development director;

(*c*) signed an S&MA with Muirhead in conjunction with the NEB's agreements with Muirhead;

(*d*) allowed Logica VTS to proceed with developing the new 2200 word processor;

(*e*) agreed to purchase from Logica VTS the right to sell the Unicom System;

(*f*) set up the Urwick-Nexos joint venture;

(*g*) acquired UDS;

(*h*) acquired offices in Bristol and in the Centre Point building in London;

(*i*) expanded its staff from around 6 to around 144, including about 100 former UDS staff.

5.25 Following NEB approval of its Corporate Plan Nexos entered into a licence greement with Delphi in August 1979 paying $2m (then equivalent to £897,890) for the cence. That month Nexos was joined by the executive director responsible for the finance, Ir J D Wilkinson, and the following month by the development director, Dr W P L Wilby.

greements with Muirhead

5.26 Throughout the early months of Nexos' existence the NEB had been trying to nclude an agreement with Muirhead. The NEB continued to conduct these negotiations nd, except for the side-letter referred to below, Nexos appears not to have been involved the negotiations.

5.27 Mr Moffat told us that by the time the agreement between Muirhead and the NEB ad been finally reached by late summer 1979 the office facsimile products of Muirhead ere virtually obsolete. He explained to us that whilst Muirhead had been manufacturing nd selling a range of Group 1 facsimile machines for some time the market was developing ast and future sales lay increasingly in Group 2 machines. The distinctive feature of Group machines was that they had a common communications protocol whereas Group 1 achines reflected manufacturers' own methods and were not generally compatible with ne another.

5.28 Mr Moffat told us that in order to stay in the market, Muirhead were rushing to try o make one of their machines compatible with the Group 2 standard. However, during the ourse of final negotiations Muirhead, realising that this solution would not be sufficient ecause of the cheaper Japanese machines becoming available, reached an agreement with KI of Japan to become a distributor of its OKI 6000 facsimile machine. Mr Moffat said at this was a much more advanced and lower cost machine than the Muirhead products ut with lower print quality. Muirhead were unwilling at that stage to disclose to Nexos the urchase price they had agreed with OKI but it was agreed between Muirhead and Nexos at the OKI machines (which were Group 2) would be included in the Nexos product ange.

5.29 The principal office facsimile machine in Muirhead's range had been the K442G nd the machine that Muirhead were trying to make compatible with the Group 2 standard as called the K442G T30. Nexos accordingly agreed to only a limited amount of roduction by Muirhead of the K442G T30 machines, which were intended to meet the

demands of existing Muirhead customers and applications requiring higher quality imag transmission than the OKI machines offered.

5.30 Mr Moffat explained to us that although the Nexos founders considered Muirhea was being overtaken, particularly by the Japanese, they did not feel that this invalidated th overall concept. Facsimile technology was wanted for the longer term in order to build th kind of system Nexos was intended to develop, since storage and forwarding of imag would be a key part of the system. Although Muirhead were running out of time in th market with their existing range, the thought was that their margins on the OKI produ would help keep them going while they were undertaking their part of Nexos' developme programme.

5.31 The agreements with Muirhead were signed in September 1979. In summary, th effect of these agreements appears to me to have been:—

(*a*) Muirhead's operating subsidiary Muirhead Data Communications Lt ("MDCL"), which manufactured and sold its office facsimile products, formed new subsidiary called Muirhead Office Systems Ltd ("MOSL");

(*b*) The NEB subscribed £210,000 for a 25% shareholding in MOSL;

(*c*) MDCL granted MOSL the right to sell and service its office facsimile products an to develop them, but not manufacture them:—

(i) the transfer price from MDCL to MOSL for these products to be at cost MDCL plus a margin to be agreed between MDCL and MOSL;

(ii) MOSL to order product from MDCL every 9 months for delivery in th following 9 to 18 months;

(*d*) In parallel, MOSL granted Nexos the right to sell and service the MDCL offic facsimile products:—

(i) the transfer price from MOSL to Nexos for these products to be at an amou equal to the cost to MOSL and MDCL of producing and developing the produ plus a margin to be agreed between MOSL and Nexos;

(ii) Nexos to order product from MOSL every 9 months for delivery in th following 9 to 18 months;

(*e*) Nexos to offer MOSL first refusal on any Nexos financed contracts to develop manufacture new facsimile products;

(*f*) In parallel, MOSL to offer MDCL first refusal on any contract to manufacture an new facsimile product developed by MOSL.

5.32 Sir Edward Fennessy, a director of Muirhead, was subsequently appointed non-executive director of Nexos, a position he continued to occupy until October 1981.

5.33 As with the Logica VTS S&MA, the MOSL S&MA did not provide for specif transfer prices but merely stated a range within which Nexos and MOSL were left to agr prices. However, before signing the MOSL S&MA Nexos agreed provisional transf prices for the first 15 months for the existing products and the K442G T30. A side letter the S&MA recorded the numbers of products expected to be ordered by and delivered Nexos, the provisional transfer prices to Nexos and the end-user prices for these product The quantities ordered and the transfer prices are set-out in Section 9 of this report.

Unicom

5.34 Logica VTS had two principal products at the time the NEB had conclude negotiating the S&MA at the beginning of the year. The first was Unicom, which was shared logic word processor system using a number of connected word processing wo stations. The second was the VTS 100 which was a stand-alone word processor. The S&M with Nexos, negotiated by the NEB, gave Nexos the right to sell the latter but not th former product. An NEB Paper indicated that for reasons of continuity Logica VTS wou continue to market and maintain Unicom systems until Unicom was superseded. Thu whilst the S&MA envisaged the sales and support staff of Logica VTS transferring to Nex to form the nucleus of its sales and support staff, Logica VTS would also need some sal and support staff to sell and maintain Unicom systems.

5.35 Mr Moffat told us that Unicom was a machine appropriate for large customers. He id that Nexos needed large customers itself because they were most likely to be the users sophisticated systems of the sort Nexos would build and therefore there were going to be oblems as long as Logica VTS retained the Unicom marketing rights. Mr Moffat said it as agreed by the NEB, Logica VTS and Nexos in the summer of 1979 that Nexos should y out the right to sell Unicom (and take over Logica VTS' sales force) on the basis of the pital value of the running revenue forecast to accrue from Unicom's sales. Nexos bsequently paid £0.5m to Logica in instalments between February 1980 and January 1981 r the right to sell Unicom. Mr Moffat told us that in the event Nexos failed to achieve the vel of sales of Unicom forecast by Logica during the purchase negotiations.

rwick-Nexos Limited

5.36 Following approval of the Corporate Plan by the NEB the office systems education mpany, Urwick-Nexos, was established as a joint venture between Nexos and Urwick rr.

urchase of UDS

5.37 Nexos purchased UDS in October. The cost was stated to be £590,000 but in fact e true cost to Nexos of the acquisition was £890,000 since, as part of the acquisition rangements, it was also necessary to provide £300,000 to UDS to re-finance its rrowings. Following the acquisition its name was changed to Nexos (United Kingdom) mited ("NUKL").

remises

5.38 UDS operated from eight locations in the UK including its head office in Thame. exos acquired offices in Bristol and in the Centre Point building in London.

aff

5.39 The total staff of the Nexos group increased from about 6 to around 144 by the end 1979, of whom about 100 were former UDS staff.

5.40 Mr Dunbar left the NEB in October and as a result ceased to be a director of Nexos. he executive Deputy Chairman of the NEB was appointed chairman in his place. owever, in November the entire Board of the NEB resigned and as a result he ceased to e a director of Nexos shortly thereafter. Efforts to obtain a chairman were not successful nd the chair at Nexos board meetings was taken by Mr Dawson until February 1981 when Ir M R Harris was appointed to the board as non-executive chairman. Mr Dawson had een a director of Nexos from the start. Mr Dunbar told us that, in his opinion, the lack of a nairman would have been crucial as it was the focal position in Nexos' relationship with its ppliers, bearing in mind the NEB shareholdings in the suppliers.

HE FIRST HALF OF 1980

5.41 At the beginning of 1980 Nexos was joined by its sales and marketing director, Mr P G Hooton.

5.42 In January Nexos took over the selling of Muirhead's office facsimile machines and e six sales staff involved transferred from Muirhead to NUKL. The following month exos took over the selling of the VTS 100 and of Unicom and the relevant staff transferred om Logica VTS to NUKL.

5.43 Following the resignation of the members of the NEB Board in November 1979 a ew Board was appointed under the chairmanship of Sir Arthur Knight. By March 1980 the ew Board had carried out a review of the NEB's strategy and had instituted a programme r reviewing the NEB's more significant investments. Nexos was one of the investments arked down for review by the Board.

5.44 The new NEB Board received a presentation on Nexos from Mr Moffat at its eeting in February 1980. They noted that the Nexos approach was one that carried a high sk and suggested that when the Nexos Corporate Plan for 1980 was considered by the

NEB later that year (then expected to be the May or June Board meeting) there might be a need for independent advice on Nexos' business strategy.

5.45 It seems that in early 1980 the NEB's perception of Nexos was that it was only just beginning to trade, having acquired UDS in October 1979, the Muirhead office facsimile sales in Janaury 1980 and the Logica VTS sales in February 1980. Thus it would have appeared to the Board that although a thorough review of Nexos seemed necessary, given other priorities, it could take place as part of the normal annual corporate planning arrangements. The nature of the review and who should conduct it was not decided upon until after Nexos had submitted its Corporate Plan dated July 1980.

Rapid Expansion of Nexos

5.46 However, in the first half of 1980 Nexos greatly increased its activities. During this period Nexos staff increased from 144 to 307. This increase included the 6 Muirhead staff and about 33 from Logica VTS.

5.47 Early in 1980 a Delta Marketing Department was set up, which had grown to 15 staff by the end of June. A European Marketing Department was also set up, which comprised 5 staff by this date. In addition, there was a separate Central Marketing Department which numbered 4.

5.48 Nexos set up a Development Department, which numbered 22 by the end of June, to plan and manage (and, in one case, undertake) the various development projects then being undertaken. In addition to the Delta project and the development of the 2200 word processor these projects included a system for the rapid acquisition of facsimile images and for their storage and transmission (the Avon and Tyne projects), enhancements to the Unicom and the development of the K442G T30 facsimile machine. Also being actively considered were a shared facility version of the 2200 word processor, a local area network system, a cheaper more limited version of the Delta and a number of other ideas.

5.49 Although Nexos had no new products to sell, it appears that most of the increase in staff numbers was in staff occupied in the sales organisation. As well as greatly expanding the staff numbers of NUKL, Nexos also set up a sales operation in Ireland, with two branches, and another in W Germany.

5.50 Mr Moffat told us that he and the Nexos management were working to the 1979 Corporate Plan in the belief that £20m funding was available. However, this Plan evisaged Nexos drawing £11m by the end of 1980, whereas it had virtually drawn this sum by July 1980 having drawn £9.4m by March 1980.

Build-up of the Sales Organisation

5.51 The turnover of UDS at the time of its acquisition was said to be barely sufficient for the gross profit thereon to cover its overheads, about one half of which were staff costs (certainly UDS was not making profits when it was purchased). The only additional products immediately available for it to sell were the VTS 100, Unicom and the Muirhead office facsimile machines but the sales and support staff for these products transferred from Muirhead and Logica VTS to UDS (now renamed NUKL). It had always been recognised that Delta would be too sophisticated to sell through UDS.

5.52 Despite the effective lack of additional products at this stage, Nexos embarked upon a policy of rapidly building up the size of its sales organisation by expanding NUKL and setting up sales operations in Ireland and W Germany. It appears that the Nexos management wanted to have the capacity to achieve a high level of sales of the 2200 word processor from the moment it became available.

5.53 This was a very high risk policy to adopt because the cost of the additional staff, together with the associated additional overhead cost, would have to be borne until the product was available to deliver to customers in volume. It also assumed that eventually Nexos would be able to achieve the level of sales necessary to cover the additional staff and overhead costs.

5.54 In the event Nexos never achieved a level of turnover sufficient even to cover the el of operating expenses of its UK sales and service organisation (without taking account NOSL "head office" and development expenditure). The action of Nexos in building up e size of its sales organisations in 1980 in advance of having additional products to deliver customers and, more importantly, a proven market for them appears to me to have been najor factor in causing the subsequent failure of Nexos. Effectively Nexos' management ked everything on the success of one new product, the 2200 word processor.

5.55 Mr Hooton told us that when he joined Nexos its first new product, the 2200, was to launched in June 1980. He said he took the view that Nexos had to go for a large market are from the start if the intention was to take on the big league like ICL, IBM, etc. He plained that such a product would have a life of perhaps some five years from the date of announcement and therefore a fast marketing start-up was necessary. He said the ginal idea was to have a sales force of the necessary size by June 1980.

5.56 Mr Moffat told us that a slow sales build-up would have risked competitors taking arket share; also that Nexos judged that it had to go in on the scale that it did in order to t the necessary scale of operations to attract large account customers.

5.57 Mr Wilkinson told us the reason for recruiting and training a large sales ganisation prior to Nexos having supplies of 2200 to deliver to customers was because of e need to move quickly to build a large company during the time the "window of portunity" was seen to exist. He said that this course was acknowledged as being of high k and was too risky for a private sector company to adopt. He explained that, at that ne, one of the purposes of the NEB was to back high risk but high opportunity projects at the private sector would not back.

5.58 Mr Hooton told us that originally the Nexos management were thinking of a June nouncement of the 2200. However, Nexos records indicate that its management appears have begun to build up the sales organisation from the beginning of 1980 in the pectation that the 2200 could be "launched" on 16th April at the Hanover Fair. The netable for the development of the 2200 word processor is dealt with separately in section of this report. On the basis of the Logica VTS Development Plan this would have meant me 3 months of sales activity before the first production machines could have been ready July 1980.

5.59 It appears that in addition to deciding to build up the sales organisation in advance having more products to sell, the Nexos management also decided to stick to this plan en when it became clear to them in March 1980 that the 2200 would not be available for le until later than previously expected. A document on operating forecasts dated 24 April 80 prepared by Nexos for the NEB states "The VTS 2200 will not now be available for pply to customers until September 1980, a slippage of 3 months". However, it later states he delay in the availability of the VTS 2200 obviously affects our staff requirements but nior marketing management has decided not to defer the recruitment programme cided upon at the start of the year." The significance of any delay in the availability of the oduct seems to have been recognised since the record of a sales meeting on 3rd March 80 shows the point was made that from May onwards the 2200 specification and timing re critical to plans and Mr Hooton is recorded as being worried and going to look into the uation urgently.

5.60 In the six months to 30 June 1980 Nexos' turnover was £1.834m (all by NUKL) mprising:—

	£K	£K
JDS" Products - Ricoh "C" Text Word processor	577	
- Ricoh Printer	158	
		735
Nexos" Products - Facsimile Machines	382	
- VTS 100	150	
- Unicom	142	
		674
rvice and supplies		425
		1,834

5.61 During the first half of 1980 a number of attempts were made to find a chairman for Nexos. Because of the hiatus at the NEB caused by the resignation of the Board under Sir Leslie Murphy and the need for the new Board to settle in, Mr Moffat appointed head hunters to look for a chairman. However, Sir Arthur Knight took a personal interest in the matter and interviewed a number of people for the task. None of these attempts was successful and by July 1980 it would have been clear that it would not be possible to appoint a chairman until a decision had been reached on the review of Nexos.

The July 1980 Corporate Plan

5.62 Mr Moffat told us that before putting together the July 1980 Corporate Plan he agreed the objectives of Nexos, against which to plan, with Mr I Halliday, the recently appointed chief executive of the NEB.

5.63 The Plan prepared by Nexos included financial forecasts for the five years 1980 to 1984. These showed a theoretical funding requirement of £26.75m (inclusive of existing NEB investment) on the basis of which Nexos asked for a total of £25m (inclusive of existing NEB investment).

5.64 Mr Moffat told us that when he presented the Plan to the NEB Board in July 1980 he started by restating the objectives but it became clear that the Board were not committed to them and they were set aside for the purposes of the discussion. He told us that if he had been told that the objective was to construct the most robust company that could be had for £15m to £20m he would have set about the Plan in a very different way.

5.65 It appears to me, from a letter written by Mr Moffat to Logica VTS, that he knew earlier that month that the NEB would not approve any additional funding to that already approved. It also appears to me that when he attended the meeting of the NEB Board Mr Moffat already knew that the NEB had decided to commission an independent review of Nexos pending which no further funding would be authorised.

5.66 The NEB Board minutes record Mr Moffat as saying that Nexos was hoping for NEB approval of £25m funding and acknowledgement that up to £40m might be required for the company to take full advantage of commercial opportunities. However, he accepted that it would be unrealistic to expect approval pending the outcome of the NEB's review of Nexos. He sought interim funding to maintain Nexos' manufacturing programme and said that a further £0.8m, bringing the total to £15.8m, would be needed on the expectation that the review would be completed by the end of the year. This was agreed by the NEB Board, who also decided that the review should proceed as rapidly as possible and should investigate:—

(*a*) whether NEB funding should be contained within £25m; and

(*b*) the prospects of attracting a private sector partner into the investment.

DoI Approval of Further £800,000 Investment

5.67 The NEB then sought the Department's consent to an £800,000 increase in funding for Nexos. This was necessary because the Department's consent to the establishment of Nexos, given in November 1978, had been on the basis of an initial commitment of £15m and, although the NEB had approved the 1979 Nexos Corporate Plan and its implied £20m commitment, consent for any amount above £15m had not yet been sought from the Department. The NEB sought consent for a further £0.8m on the basis that this was necessary to maintain Nexos' manufacturing plans while the NEB carried out a review of the company and this consent was given by the Department in July 1980.

NEB Review of Nexos

5.68 The review was conducted by a team headed by the NEB Board member Sir George Macfarlane and consisting of four persons from Arthur Andersen & Co and two from Patscentre International assisted by four NEB staff, including Mr Dawson.

5.69 The results of the review together with a revised summary corporate plan were contained in a bulky document which was presented to the NEB Board in October 1980 by

r George Macfarlane and Mr Dawson. This document did not contain any commendations but limited itself to pointing out the key issues and options.

5.70 The document included a summary of the review team's assessment which ncluded that:—

(*a*) Nexos had set itself ambitious targets for growth in sales volume and there was a significant risk that these targets would not be achieved;

(*b*) there was a risk that the NEB might have to provide further funds;

(*c*) the product strategy and products defined so far were competitive;

(*d*) the planned rate of return to the NEB was high and it would require major shocks before the rate of return was reduced to an unacceptable level;

(*e*) the plan was critically dependent on the success in the UK in 1981 of the about to be launched 2200.

5.71 In presenting the results of the review to the NEB Board, Sir George Macfarlane iid that in his personal view Nexos was clearly a high risk venture and he could not say with ıy confidence whether the company would be successful if it were to rely exclusively on its :xt/image products. The key question was whether Nexos could become a market leader in ffice systems as a result of its voice products, for which the market was largely unproven. [e said that in his view it would be right for the NEB to continue to support Nexos at least ntil the end of 1981, during which time it should be possible to prove market prospects for ıe Delta system in the UK and to establish Exxon's intentions for Delta in the United tates market. The proposed joint venture with British Telecom (referred to in paragraph .18) would be a very important part of this market assessment since it would make Delta a ıow piece in the UK and would demonstrate commitment by a PTT, which would be rucial for the success of the controller concept.

5.72 In discussing the review the NEB Board noted that Nexos was heavily dependent n outside contractors and there was therefore a substantial risk of production problems. Also that it would be difficult to justify further NEB investment in Nexos as a company ıecialising in facsimile and word processing products. The case for NEB involvement ested on the premise that Nexos might obtain a substantial share of the market for systems ı 3-5 years time, developing market acceptance for its ring main and Delta products on the ack of its conventional products.

5.73 The NEB Board agreed that there were very substantial risks attached to its ontinuing support for Nexos but, in view of the special statutory objectives of the NEB, greed that funding of £12m in 1981 should be approved and that it should approve in rinciple the Nexos Corporate Plan for 1980-84 subject to the establishment of appropriate milestones" for Nexos.

5.74 This took the total funding approved by the NEB Board to £27.8m although the Board effectively approved a Corporate Plan which envisaged a funding requirement of 35.155m by 1984. However, in just approving a further £12m the Board only approved the unding forecast by the Plan to be required to the end of 1981. The Board also decided to seek as a matter of some urgency to test Exxon's attitude to the Delta system; to resolve ssues affecting Nexos' relationship with its suppliers; and to appoint a strong non-xecutive Chairman of Nexos".

5.75 As the review was of fundamental importance to the decision by the NEB to ontinue funding Nexos, the contents of the review document and its consideration by the IEB Board are described in more detail at Appendix 9.

5.76 Regardless of the NEB's original concept of Nexos and the question as to the isdom of Nexos building up such a large organisation so rapidly, the review team and the IEB had to consider Nexos as it existed in or about September 1980. By then it had become n organisation of about 350 people with overheads to match, in addition to which there as a substantial development programme in progress. It appears to me at that time Nexos' ırnover from "inherited" products was running at £6.75m pa whereas its overhead and evelopment expenditure was running at an annual rate of £15m. The review team

commented that Nexos had grown its establishment and costs to support sales five times larger.

5.77 I doubt that reducing the size of Nexos would have been a practical option as it would have involved great cost and almost certainly would have undermined the prospects of Nexos progressing any further towards its longer term integrated office systems objective. Failure to continue funding Nexos would have led to its immediate insolvency resulting in an almost certain loss by the NEB of the money it had invested which, by the end of October 1980, amounted to £14.9m.

5.78 Therefore the NEB had to assess the prospects of Nexos becoming profitable, the further investment needed to achieve this and the potential profit on such further investment.

Cash Crisis at End of 1980

5.79 Early in August 1980 it became clear that it would be no longer possible to launch the 2200 word processor at the beginning of September. The launch finally took place in the middle of October. The story is set out more fully in Section 7 of this report.

5.80 Until the middle of 1980 Nexos had been operating on the assumption that £20m would be available from the NEB although it knew that it would not be given these funds without the consent of the Secretary of State and consent had only been given for £15m. At the NEB Board meeting on 18 July 1980 Mr Moffat was told that Nexos would have to live within the total funding of £15.8m until the independent review had been completed. Additional funding might be approved following this review but its outcome might not be known until the end of the year.

5.81 Dr Wilby told us that, in the light of the NEB's decision on funding, Nexos imposed an immediate freeze on recruitment in the development department. Nevertheless, whilst the independent review was taking place, and afterwards whilst awaiting the Secretary of State's consent to the funding approved by the NEB Board in October 1980, Nexos continued to increase its overall staff numbers. They increased from 307 at the end of June 1980 to 405 by the end of December 1980.

5.82 Nexos failed by a wide margin to keep within the £15.8m limit. It drew the last of the £15.8m from the NEB in November 1980 and immediately ran into a cash crisis. This had two particular consequences: first, Nexos was forced to sell its car fleet to a leasing company and then lease it back; second, the NEB had to press the Department to consent to limited interim funding pending the outcome of its consideration of the NEB's request for consent to the total funding forecast in Nexos' Corporate Plan. This was the beginning of a phase which has been referred to as the period of "drip-feed" funding, which lasted until February 1981 when the Secretary of State consented to the total funding of £35.1m.

5.83 It has been suggested that Nexos expected to be selling the 2200 by the summer of 1980 and that the delay by Logica VTS was a cause of Nexos' cash crisis. In my view such suggestions are ill-founded. Since 4 April 1980 the Nexos Development Department had been working on the assumption that first customer shipments of the 2200 would commence in the first week of November 1980. Whilst the sales organisation originally appears to have had different expectations, by the summer of 1980 these expectations were in line with the Development Department. On the basis of first customer shipments commencing in the first week of November and allowing for customers taking four to six weeks credit, I consider that it would have been unrealistic for Nexos to have anticipated any benefit in 1980 from cash flows from the sales of the 2200. Since Nexos had spent the last of the £15.8m by December, when it sold and leased back its car fleet, I do not consider the delay in the 2200 could have been the cause of the end 1980 cash crisis.

5.84 In my view, Nexos' cash crisis resulted from its management continuing to increase the rate of spending in the second half of 1980 despite knowing since July that they might have to live within total NEB funding of £15.8m for the foreseeable future. Indeed, in my view, Nexos continued to increase its expenditure to such an extent that it would not have been able to contain its operations within the £20m funding limit approved by the previous NEB Board in July 1979.

5.85 It has been represented that the sale and lease back of the car fleet was necessary in rder to pay the wages because of delay in providing Nexos with adequate funding. I nsider this misleading since records at the NEB indicate that in July 1980 it was cognised by Nexos as a necessary step in order that it could stay within the £15.8m nding limit until the end of 1980.

oI Consideration of Request for Further Funding

5.86 Following the NEB Board's approval of the revised Corporate Plan the NEB wrote four page letter, dated 27 October 1980, to the Department requesting consent to crease its investment in Nexos to a total of £35.2m. The letter said that the NEB had mpleted a review of Nexos centred on its 1980/84 Corporate Plan. It summarised the orporate Plan, the review team's views and the NEB Board's views.

5.87 It stated that the Nexos strategy involved capturing a significant share of the UK nd European market for office systems by 1984 and in turn capturing 25% of the UK word rocessor and facsimile markets by the end of 1981. The letter said that the review team had formed the NEB that the Nexos strategy was sensible but highly ambitious. It was lanning to capture a large share of the market for sophisticated office equipment with a roduct (the 2200) which was competitive but not outstanding. It said that Nexos' unique dvantage was the Delta processor but pointed out that it was not possible at that stage to ay whether the Delta system would become a major success since the market for voice ystems had yet to be established.

5.88 The letter referred to the sensitivity analyses carried out by the review team which howed that £50m might be needed to develop Nexos to the point where it could generate dequate profits. However, the letter said that the most gloomy sensitivity analyses used in he review still showed a company worth £100m by the end of 1984 for an undiscounted nvestment of £50m.

5.89 The letter said that the NEB Board had noted that Nexos' plans were ambitious and f delivered in full would provide the NEB with a substantial return. On the other hand the Board had also noted that the strategy was high risk and that if it failed there might be little o show for a substantial expenditure of public money. The letter reported that the NEB Board had agreed that it would be difficult to justify further NEB investment in a company pecialising in word processor and facsimile products and that the case for further nvestment rested on the possibility of Nexos becoming a major force in the European narket for office systems. The letter also said that the Board had noted that Nexos had uffered from the production difficulties of its major suppliers (Logica VTS and MOSL) in ts first year of operation.

5.90 The letter reported that, noting all the risks, the NEB Board had agreed to continue o support Nexos and to approve its Corporate Plan; that total NEB funding should be ontained within the £35.2m envisaged by the Corporate Plan and that steps should be aken no later than mid-1981 to set limits to the risks attached to the NEB's investment, at vhich time the Board would examine the prospects for introducing private sector finance.

5.91 Finally, the letter said that in the view of the restrictions placed on Nexos' xpenditure earlier in the year there was some urgency attached to the application for onsent.

5.92 In addition to the NEB's formal letter to the Department requesting consent for an ncreased investment in Nexos, Sir Arthur Knight wrote to the then Secretary of State, Sir Keith Joseph, on 28 October 1980. In this letter he said that whilst it was not possible to say vhether the current Board would have supported the setting up of Nexos in its current orm, they were clear that having regard to the NEB's statutory duties and to Nexos' rogress to date it would be quite wrong to withdraw support from Nexos at that time. He tated that it would not be possible to say until 1983 or 1984 at the earliest whether the nvestment had paid off. In order to limit risks the NEB were tightening their monitoring ontrols over Nexos and would have a further comprehensive review in the middle of the ollowing year to check, among other things, that satisfactory progress had been made in esolving a number of major issues which included Nexos' relationship with its suppliers.

Finally, Sir Arthur Knight said that in the course of the following year the NEB would be investigating the prospects for introducing private sector finance into Nexos and/or strengthening the company through a link with a UK or overseas manufacturer of compatible products.

5.93 In requesting the Department's consent to further investment in Nexos, the NEB failed to convey to the Department the true urgency of the situation: the NEB's letter merely stated that there was some urgency attached to the application for consent. The reason may have been that the NEB itself failed to appreciate the true urgency of the situation.

5.94 The 3½ months which had elapsed between the NEB's consideration of the Nexos Corporate Plan in July and its consideration of the independent review in October combined with the continued increase in Nexos' spending meant that by the end of October 1980, Nexos had nearly run out of funds. By the end of October 1980 only £907,000 of the £15.8m approved funding remained undrawn, although Nexos had some unspent cash in its bank account. The monthly financial returns to the NEB for the three months to the end of September showed that Nexos was by then spending an average of £1.5m per month. In reality, by the end of October 1980 Nexos had actually spent £14.4m out of the £15.8m approved. Following the NEB Board's decision on 17 October there was a ten day interval before the NEB wrote to the Department by which time Nexos was about a month away from running out of money.

5.95 The Department took the view that it would need to consider the Nexos case in some depth before deciding whether to consent to the increased level of funding, despite the NEB having pointed out that there was some urgency attached to the application. This is probably because the NEB had failed to commuinicate the true degree of urgency of Nexos' situation to the Department. There followed a meeting between Mr Moffat and the Head of the Department's Information Technology Division, at which Mr Moffat explained Nexos' plans at some length, and a presentation a week later of Nexos' plans to a large delegation of the Department's officials.

5.96 On 8 December 1980, Sir Arthur Knight wrote a further letter to Sir Keith Joseph expressing concern at the consequences of the delay in a decision and saying that Nexos was likely to run out of money within a week or so and that the delay in obtaining consent was damaging Nexos' relationship with its suppliers. The following day the NEB wrote to the Department saying that without further funds Nexos would be obliged to go into immediate liquidation and that it was believed this would cause Logica VTS to fail, as well as having adverse consequences for Muirhead.

5.97 On 11 December Ministers decided to provide £5.3m of further finance for Nexos in order to keep it going until the end of February 1981 whilst the NEB actively sought private sector funding, on the basis that the alternative was immediate bankruptcy for Nexos.

5.98 I consider that, at that time, the sale of Nexos to the private sector or the provision of further finance by private sector sources were unlikely possibilities although they might have been more likely a year later if the full funding for 1981 had been made available by the NEB and provided that Nexos had then achieved its October 1980 Corporate Plan objectives for 1981. Therefore, in December 1980, in my view, there were really only two options: either to cease further funding or to consent to the funding required for 1981. Ending funding at that stage in Nexos' life would have resulted in a complete loss of the NEB's investment. The reason is simply that the nature of Nexos' activities was such that the NEB's funding was being used by Nexos either for expenditure which did not create assets or for expenditure on acquiring assets which, whilst of value to an on-going business, were likely to realise negligible amounts on a break-up of Nexos' business. Therefore, in considering the potential investment value from providing further funding, all previous funding could be regarded as lost.

5.99 As indicated below, "drip-feed" funding resulted in uncertainty as to Nexos' future and this caused damage to Nexos.

5.100 Between December 1980 and February 1981 there was much activity within the Department and between the Department and the NEB regarding Nexos, but the NEB failed to find a private sector partner although there was some interest which it thought might lead to a "deal" in the second half of 1981. In mid-December Sir Arthur Knight resigned as NEB Chairman and Sir John King (now Lord King) was acting Chairman until Sir Frederick Wood was appointed Chairman with effect from 1 February 1981. In addition Mr I Halliday, who had been Chief Executive of the NEB for about nine months, resigned at the end of November 1980 and Mr W B Willott, who had been Secretary of the NEB, became its acting Chief Executive.

5.101 In January the Department agreed to the provision of a further £1m with the object of keeping Nexos in funds until the end of April 1981. However, "drip-feed" funding was causing Nexos to suffer a lack of credibility in the market place just at the very time it was trying to sell its first "new" product, the 2200. Potential large customers were seeking assurances from the NEB as to Nexos' future, but failing to obtain the degree of assurance that they required. Similarly British Telecom sought assurance in connection with the proposed telephone answering service bureau joint venture with Nexos, referred to in Section 6. Furthermore, the Nexos management were suffering from a loss of morale as were its staff, who were beginning to leave.

5.102 Consequently a meeting was arranged for 19 February 1981 between Mr Tebbit, Mr Baker and Sir Frederick Wood. Mr Tebbit, as the recently appointed Minister of State for Industry, was responsible for the NEB and Mr Baker had recently been appointed Minister for Information Technology. At the meeting Sir Frederick Wood said that there were three alternative courses of action:—

(i) to continue to "drip-feed" Nexos;

(ii) to wind-up Nexos at that stage;

(iii) to permit additional funding of £13m, being the balance of the £35.1m envisaged in the Nexos October 1980 Corporate Plan.

He argued that the "drip feed" solution was fatal; it would not restore confidence in Nexos, would undermine its market prospects, was having a serious effect on its management and would eventually lead to its demise without any commensurate return to the NEB on its investment. Alternatively, closure at that stage would cost some £5m and there would be very little chance of getting any money out of Nexos.

5.103 In discussion, Sir Frederick Wood reported the appointment of three non-executive directors including Mr Martin Harris as chairman. If the additional £13m were to be provided he agreed that if Nexos was not succeeding commercially the NEB would take the necessary steps to ensure that the total costs, including those of closure, were contained within the additional £13m. Also that the NEB would provide the Department with an assessment of Nexos' prospects, its views on the quality of Nexos' senior management and would press ahead with talks with private sector partners as rapidly and as effectively as possible.

5.104 On 24 February Ministers agreed to the provision of a further £13m on the basis of the understanding agreed with Sir Frederick Wood at the meeting and subject to a number of conditions.

Pressure by Nexos Executive Directors for a Merger with Logica VTS

5.105 Mr Willott told us that in mid-January 1981 the Nexos executive directors told the NEB that they considered a merger of Nexos and Logica VTS to be necessary in order to resolve the problems in their relationship with Logica VTS. By mid-February 1981 the executive directors were pressing this view very strongly with the NEB.

5.106 It is clear that at this time the executive directors were strongly presssing the NEB to procure a merger with Logica VTS, their stated reasons being in order to solve problems in the relationship and because the S&MA was unsatisfactory and grossly disadvantageous to Nexos. However, I question whether this pressure was because of their perception of problems in the relationship. I am somewhat of the view that the executive directors were

motivated more by a belief that, firstly, Ministers would not consent to the NEB providing all the funding which would be required to achieve their objective of Nexos becoming a major office systems company and, secondly that Nexos could not obtain private sector funding without first merging with Logica VTS. I am inclined to this view because of the following:—

(*a*) I question whether the problems in the relationship were anything more than the normal problems in commercial relationships, exacerbated in this case by difficult personalities. Problems in the relationship with Logica VTS were revealed in the independent review concluded in mid-October 1980 but they did not surface as fundamental issues critical to the continued existence of Nexos as an NEB subsidiary.

(*b*) Mr Moffat had a meeting with Mr Baker on 16 January 1981. He did not take this opportunity to voice any concern that a merger with Logica VTS was considered necessary as the only possible solution of the problems with that company. Yet on 18 February the executive directors went over the head of the NEB in writing direct to Sir Keith Joseph to seek his support for a merger (See paragraph 11.13).

(*c*) At some time prior to 18 February the executive directors apparently received advice from Cazenove & Co to the effect that a merger with Logica VTS would be a prerequisite to private sector investment in Nexos.

5.107 Indeed, Mr Wilkinson explained to us that the executive directors were trying to procure a merger because they understood the Secretary of State to have said that there would be no more money for Nexos unless it could secure private sector funding and they understood that the City would not be interested in Nexos while it was constrained by the existing S&MA.

5.108 Mr Moffat explained to us that he did not raise the problem of Logica at his meeting with Mr Baker as he had not felt it right, firstly because he had not then exhausted the proper channel of the NEB and secondly in view of Mr Baker's previous connections with Logica.

5.109 Mr Moffat was referring to the fact that before being appointed a Minister Mr Baker had acted as a consultant to Logica and had a shareholding in the Logica group. When he became a Minister, after seeking official advice, Mr Baker disposed of his shares to trusts in which he had no interest and over which he had no control. He also discontinued his consultancy activities.

5.110 The executive directors of Nexos pressed the NEB to procure a merger with Logica VTS, their stated reasons being in order to solve the problems in the relationship and because they considered the S&MA was unsatisfactory and grossly disadvantageous to Nexos. That the S&MA was unsatisfactory was supported by Counsel's Opinion. However, it appears from Nexos' records that the executive directors' efforts to pursuade the NEB to procure a merger did not result from this Opinion: rather that an Opinion to this effect was specifically sought for use in their efforts to obtain a merger.

5.111 The NEB does not appear to have attached much weight to the view of the Nexos directors in mid-February that Nexos should be terminated unless it was immediately merged with Logica VTS. Mr Willott told us that the NEB believed that the Nexos executives wanted a merger primarily because of their desire to bring Logica VTS under their control and so resolve the problems in their relations with Logica VTS. These problems were perceived to be:—

(*a*) the delay in the development of the 2200 word processor;

(*b*) poor quality of the initial production of the 2200;

(*c*) disputes over amounts due by Nexos to Logica VTS.

Mr Willott told us that the NEB considered these problems to be of an operational nature and therefore primarily for the Nexos management to resolve. However, the NEB was concerned about the personality problems that appeared to have developed between the Nexos executive directors and their suppliers, Logica VTS in particular.

5.112 Mr Willott also told us he discussed with Logica on several occasions the ossibility of a merger of Nexos and Logica VTS but Logica were not interested in a deal at hat time and the NEB were powerless to force a merger.

5.113 It is also relevant that at this time Mr Willott was having discussions with a large umber of private sector companies in the UK and overseas with a view to negotiating a rivate sector partner for Nexos, as insisted upon by Ministers. The progress of these iscussions was reported to the Department on 29 January 1981 and may have provided im with some encouragement that a private sector solution for Nexos could have been ossible without a merger with Logica VTS.

5.114 In mid-February 1981 Mr Moffat, Mr Wilkinson and Mr Hooton pressed on the NEB very strongly their view that a merger was necessary. Mr Moffat told us that when he ailed to obtain from Mr Willott an assurance that their view would be communicated to the ecretary of State prior to his decision on further funding for Nexos, the three executive irectors wrote directly to Sir Keith Joseph on 18 February. This letter is reported on in ection 10 of this report.

5.115 A copy of the letter and the accompanying letter from Mr Wilkinson were passed o the NEB by the Department. The NEB had just appointed three non-executive directors o the Board of Nexos and had asked them, *inter alia,* to assess the quality of the anagement and to draw up a new corporate plan to see whether Nexos was viable. Thus ne question of the necessity of a merger with Logica VTS was effectively rolled-over into his process.

Commencement of Sales of the 2200

5.116 Following field trials of the 2200 word processor with selected customers in December 1980, commercial sales commenced in January 1981. This resulted in an mmediate and substantial increase in the monthly rate of Nexos' sales which was sustained n February. Whilst still below budget in actual terms, sales in March rose to an even higher evel and the trend of sales in the three months to 31 March 1981 provided encouragement or the view that Nexos might achieve the level of sales forecast in the October 1980 Corporate Plan.

5.117 Towards the end of December 1980 the NEB had agreed certain "milestones" vith Nexos, this being one of the conditions the NEB Board attached to approval of Nexos' Corporate Plan in October 1980. The milestones included objectives for the level of unit ales by March and by June 1981 as well as for gross margin, profit and cash management. The milestones for March were that sales of the 2200 were to reach 60 units a month, sales f facsimile machines to reach 60 units a month and sales of a Systime small business system an expediency measure to sell a product of an NEB associated company so as to provide a ontribution to Nexos' overheads) to reach 10 a month.

5.118 Performance against these milestones for the period up to the end of March 1981 ppeared promising. Although the Systime Small Business System did not become vailable to Nexos and facsimile machine sales fell below target, the 2200 sales seemed to e picking up well, and unit sales met the March milestone.

5.119 By early 1981 it had become apparent to Nexos that it would have to alter course nd place much more emphasis on quickly demonstrating commercial success in the market lace rather than on development projects in pursuit of its long term objective of becoming major office systems company. In this situation the development director, Dr Wilby, onsidered that he no longer had a role to play and he ceased to be a director early in 1981.

eview by Non-Executive Directors

5.120 Following the independent review of Nexos in 1980 the NEB had renewed its fforts to find a chairman for Nexos. Mr Willott told us that under Sir Arthur Knight there ad been a shift in the NEB's monitoring style. More responsibility was put in the hands of usted external non-executive directors who were put on the boards of NEB companies. In ebruary 1981 the NEB appointed three non-executive directors to the Board of Nexos, ffectively from the end of the month. They were Mr M R Harris, who was appointed

chairman, Mr K Frost and Mr J Oakley. Mr Willott wrote a letter to the new chairman, copied to the other two newly appointed directors, setting them three initial tasks:—

(*a*) to assess the quality of the management;

(*b*) to get a grip on the financial management;

(*c*) to draw up a new corporate plan to see whether Nexos was viable.

The last point was necessary because of the many changes since the previous corporate plan had been drawn up some five months previously. In particular, the period of "drip feed" funding had damaged Nexos' credibility in the market place and with its suppliers and had had an adverse effect on staff morale.

5.121 A new Plan was submitted to the NEB by Mr Moffat at the end of April 1981. Following its review by the Nexos Board in early May, Mr Harris wrote to the NEB stating that the three executive directors and the three recently appointed non-executive directors were firmly of the view that Nexos could not succeed if it continued to be dependent on Logica VTS for the supply or development of word processors. He went on to say that, in their view, if Nexos was to continue with its mission of becoming a business systems company it was essential that it (or the NEB on its behalf) acquired Logica VTS.

5.122 Subsequently, when Mr Harris and Mr Moffat presented the Plan to the NEB Board, the minutes record Mr Harris as saying that the three recently appointed non-executive directors had found two fundamental obstacles in the way of achievement of the NEB's ojectives for Nexos; Nexos' overheads were too high and the S&MA with Logica VTS was very restrictive. The Plan addressed this situation by recommending a merger between Nexos and Logica VTS since this should have reduced overheads and eliminated the difficulties caused by the S&MA.

5.123 It appears that the NEB may have felt that the review of Nexos by its three recently appointed non-executive directors had not been as thorough as they had been expecting. Also that a renegotiation of the Logica VTS S&MA might have been an alternative solution instead of revising the corporate structure. The minutes of the NEB Board meeting record that, whilst noting that ultimately a solution to the problems identified by Mr Harris would have to be agreed between the NEB and the Logica group, the NEB Board decided that as a first step it should gain Logica's acceptance of a direct NEB involvement in the management of both Nexos and Logica VTS. In the light of this experience the NEB expected to decide whether it would be better to renegotiate the S&MA or to seek a revised corporate structure containing Nexos and Logica VTS. However it appears that in conveying this decision to Nexos the NEB gave the impression that it had accepted that a merger with Logica VTS was necessary and was pursuing that objective.

5.124 The result of the NEB's involvement was the formulation some weeks later of a plan to merge Nexos, Logica VTS and Systems Programming Holdings Ltd (which was another NEB company) into a new company referred to as "Newco".

5.125 Mr Willott told us that the Newco idea had also included DRI and QI, which were other NEB companies, and that during May, June and July the NEB was actively talking to all these companies. Mr Willott said that at the same time he was having discussions with Mr Hughes and in particular covered the question of whether Logica Securities was prepared to sell its shareholding in Logica VTS. He also told us that at that time Logica Securities was not prepared to sell but put in a counter-proposal to take over Nexos if it was paid to do so. This idea did not find favour at the NEB, however, as at that time the NEB did not consider Logica VTS to be particularly well managed.

Failure to Achieve Adequate Sales

5.126 After the substantial increase in the monthly rate of sales following the introduction of the 2200, the sales in March 1981 proved to be a peak. After March they fell back and levelled off. Unit sales of the 2200 stayed at around 50-65 a month and facsimile sales generally less than 20 a month. This compared with the June 1981 milestones of 100 units a month for the 2200 (60 in the UK and 40 in Europe), and facsimile sales of 70 units a

nonth. Overhead and development expenditure was running at several times the amount f gross profit then being earned. I have sought reasons for the inadequate level of sales in 981.

5.127 Mr Moffat gave us a number of reasons. However, in substance they amounted to continued lack of market confidence in Nexos (apparently despite the February 1981 ecision to provide the balance of the funding) and a need by the Nexos management to evote most of their time to continuing reviews of Nexos; both of which resulted in an nability to motivate Nexos staff. With regard to facsimile sales in particular, Mr Moffat old us that a lot of competition developed in the market with the entry of NEC and others.

5.128 Mr Hooton told us that an interview given by Mr Willott to the Financial Times ad led to an unsatisfactory article on 16th June 1981. This had enabled competitors to laim that Nexos' continued existence was in doubt and thus its ability to provide after-sales naintenance. Mr Hooton emphasised to us that it was very difficult to motivate a sales force nless they felt the company was behind them. He said that at the beginning of 1981 the ales organisation was not operating to plan because of a head count freeze. This, together vith difficulties with the 2200, such as "bugs" in it and a lack of communications capability, esulted in them not selling more than they did.

5.129 Mr Wilkinson attributed the inadequate level of 2200 sales to too high a transfer rice from Logica VTS and inadequate facilities on the machine; particularly the lack of utomatic correspondence and the IBM 2780 communications facility, which he said was he industry standard.

5.130 Having considered transfer prices in 1981 and prices at which Nexos sold the 2200 o end users and to distributors I strongly doubt whether the transfer price was a major actor in the inadequate level of sales achieved by Nexos. The position with regard to the evel of functions, particularly communications and automatic correspondence facilities, is lealt with by me in section 7. The delay with the release of the automatic correspondence oftware may have been a factor in the inadequate level of sales in the second quarter of 981. However, the management of Nexos had, or should have had, ample knowledge that he 2200 would not have communications facilities in the first half of 1981.

5.131 With regard to facsimile sales Mr Wilkinson told us that there were two problems; irstly cost, because Nexos' selling price had to cover both Nexos and MOSL overheads, nd secondly lack of market confidence in the future of Nexos, particularly big account ustomers concerned with servicing arrangements.

5.132 Mr Dawson told us that from the end of 1979 the NEB or Nexos had been onstantly in the news as being under review or a cloud of uncertainty and, against this ackground, sales never took off. He said that the credibility problems were massive by the ime the 2200 became available and that the approval of funding in February 1981 did not elp very much because the public had clear knowledge of the strings that were attached to he money.

5.133 Poor reliability, resulting in a very high rate of machine failures in the first few nonths of 1981, has also been put forward as a reason for the inadequate level of 2200 sales.

5.134 Dr Wilby told us that he believed that 2200 Beta test machines (ie those in the field rial referred to in paragraph 5.116) had relatively few "bugs" and although they did have ome, this was not in any way unusual for a new product of the complexity of the 2200. He old us that some "bugs" would only have become apparent in the field when the 2200 was ut through sequences of operations not envisaged and that it was not necessary to have all inor "bugs" eliminated by the commencement of sales provided that they were promptly ixed.

5.135 In a note to the NEB of 28 April 1981, commenting on Nexos' claims of a 22% field ailure level in the period to 19 February 1981, Logica VTS stated that their examination of he Nexos data showed the true failure rate to be 11.3%, the balance being due to incidents n which no fault was found or printers required adjustment. Logica VTS also pointed out hat 83% of the machines in Nexos' sample were built before the first customer shipment

production run. I find poor reliability of the 2200 an unconvincing reason for the fall and levelling-off in sales after March 1981.

WINDING-UP OF NEXOS

5.136 Mr Willott told us that the NEB continued to fund Nexos in July and August 1981 because there still seemed the prospect of an outcome to the talks going on between the NEB and prospective partners. He told us that in mid-August 1981 Mr Hughes said Logica Securites would be prepared to sell Logica VTS if necessary but he explained that by then the Newco concept seemed a non-runner. By then it was clear that Nexos was not succeeding and Mr Willott told us that he and Sir Frederick Wood recommended to the NEB Board at its meeting on 18 September 1981 that Nexos be wound up.

5.137 Discussions were still taking place between the NEB and Gestetner with a view to it investing in Newco, but Gestetner failed to make any firm commitment to invest in Nexos by the deadline of 14 September 1981 that it had been set. At its meeting on 18 September the NEB Board (by then a sub-committee of the Council of the British Technology Group) suggested that a deal with Gestetner probably offered the best prospect of a solution to the Nexos problem. Accordingly it was agreed to press Gestetner to reach an early decision on whether, and in what form, they wished to invest in Nexos but to institute an immediate rundown of Nexos' activities.

5.138 By then it was clear to the NEB that Gestetner was not interested in Delta or in Nexos' facsimile business. Therefore it was decided that the rundown should include immediate efforts to dispose of the Delta licence and that the NEB should initiate discussions with Muirhead about the possibility of it taking over Nexos' facsimile business.

5.139 Meanwhile the overhead expenditure being incurred by Nexos was still many times the amount of gross profit being earned. Mr Willott told us that Gestetner had stated categorically that they were not interested in Nexos if it went into receivership. In order to keep the business going whilst Gestetner reached its decision it was necessary for the NEB to put more money into Nexos. This money was put in as a secured loan at call, rather than share capital as previously. This device effectively gave the NEB the ability to put Nexos into receivership if it so wished.

5.140 Early in November 1981 agreement was reached with Delphi for the termination of the Delta licence at no further cost to Nexos. Subsequently agreement was reached with Muirhead for the termination of the S&MA and transfer to MOSL of parts of Nexos' facsimile business. I do not consider that these agreements are relevant to either the failure of Nexos or to the magnitude of the NEB's loss. However, adverse comment has been levelled at them and in view of this, for the record, I give more information regarding these two agreements and the background to them in Appendices 11 and 12.

5.141 Discussions continued with Gestetner and agreement in principle was reached for Gestetner to acquire the word processing activities of Nexos together with Logica VTS, in a deal which would have involved the investment of a substantial further sum by the NEB. Heads of Agreement were signed at the end of November 1981 and it was estimated by the NEB that this deal would have had a further cost of approximately £13m.

5.142 Renewing earlier interest in the 2200, ICL contacted the NEB in December 1981 with a completely new idea of acquiring certain Nexos assets. This proposal had the attraction of not requiring the investment of more NEB money and of ICL being prepared to pay Nexos for its unsold 2200 stocks. The NEB assessed the ICL proposal at some £9m to the NEB's advantage when compared with the Gestetner deal. Furthermore it emerged that Logica were happy with the proposal. Mr Willott told us that although the NEB felt morally committed to Gestetner, Logica made it clear that they would not now agree to the Gestetner deal. Accordingly, Gestetner were told it was not possible to complete the deal and Heads of Agreement were signed between NEB, Logica and ICL in January 1982 and the contract in March 1982.

5.143 In summary the agreement provided that ICL would buy at book value Nexos' stocks of the 2200, including the Ricoh printers, parts and supplies; that Nexos and Logica

VTS mutually waived claims against each other and the S&MA ceased; that the NEB sold :s shareholdings in Logica VTS, Logica Holdings and Logica Securities for £3.445m to .ogica Securities or its nominees and that Logica Holdings repaid the NEB its loan of 100,000. In view of comment regarding the disposal of the word processor business, and in articular the earlier announcement of agreement having been reached with Gestetner, I et out in Appendix 13 a summary of the agreement with ICL and Logica together with the ackground to it.

5.144 The remaining parts of Nexos were disposed of in 1982. The UK service and naintenance business was sold in a management buy-out as was Urwick-Nexos. Mr Willott old us that the businesses in Ireland and West Germany were also disposed of.

5.145 Although Nexos as such failed, individual parts of its business have continued. We ave been told that both Urwick-Nexos and the service business are continuing. Perhaps nore importantly, we have also been told that the 2200 has become a success, although ome have pointed to additional features added to it after the demise of Nexos. I nderstand that Logica VTS has continued to manufacture it and that it has been sold in the JK both as an ICL product and as a BT Merlin product.

5.146 Mr Olson, managing director of Logica VTS, commented to us that ICL had had a onsiderable success selling the 2200 and pointed out that Logica VTS had received a Queen's Award for Technological Achievement for the 2200.

5.147 Mr Dawson told us that after ICL took over the 2200 it became a UK market eader with a similar market share to the Nexos target and it also achieved good export ales.

5.148 It has been pointed out to us that Logica VTS was a major beneficiary of the failure f Nexos. The, apparently successful, continued manufacture of the 2200 by Logica VTS ollowing the termination of the S&MA and the sale of Nexos 2200 stocks to ICL perhaps alls for some comment on the property rights in the 2200 prior to the termination of the &MA.

5.149 It appears to me that under the S&MA neither Nexos nor Logica VTS owned the roperty rights in the 2200. The S&MA effectively provided that Logica VTS had the xclusive right to manufacture the 2200 and Nexos had the exclusive right to sell it. Thus it eems to me that on a demise of one of the parties the other party could have been in a osition to both manufacture and sell the product as the first party would not have been in a osition to enforce the S&MA. I also note that, when Nexos sought Counsel's opinion on wnership of the property rights in the 2200, Counsel's view, as expressed in conference, vas said to be unfavourable to Nexos.

5.150 Thus I conclude that, given Nexos had not succeeded, neither Nexos nor the NEB ould have prevented Logica VTS from continuing with the 2200 and, therefore, the greement reached with ICL and Logica VTS was probably as good a deal as could be btained in the circumstances.

DELTA

his section outlines Nexos' involvement with the Delta development.

6.1 An American company called Delphi Communications Corporation ("Delphi"), hich was a Californian based subsidiary of Exxon Enterprises (part of the worldwide xxon Oil Group), was developing a powerful computer system called Delta intended for se in operating telephone answering systems.

6.2 Mr Moffat was introduced to Delphi by the NEB in February 1979. Mr Moffat told s that the architecture of the Delta processor being developed by Delphi was considered to e ideal for one of the key tasks envisaged by the Nexos strategists; this was as the centre iece of an integrated office system. New operating software would be required for Delta to lfil this role as opposed to operating a telephone answering system.

6.3 It appears at that stage Mr Moffat and his assistants proposed that Nexos buy the existing technology to the Delta computer; develop in the UK the necessary software to enable Delta to be used to fulfil a number of functions in an integrated office system instead of a telephone answering system; and manufacture the resultant Delta equipment in the UK for sale in the UK and the rest of Europe. A proposal along these lines formed the main part of the July 1979 Nexos Corporate Plan. Delta was referred to in the Corporate Plan as a communications management computer and stated to be probably the most advanced one then available.

6.4 The Delta machine was stated to have the advantage of being an existing product and a licence from Delphi was proposed giving Nexos exclusive rights for the manufacture and sale of Delta throughout Europe for application in office automation systems.

6.5 According to the Corporate Plan early shipments of the product for Nexos' internal use were expected to be available by mid-1980, with first customer shipments from Nexos by the end of 1980. The financial plan forecast sales of two units in 1980 and seven units in 1981 with sales revenue of £719,000 and £3,663,000 respectively.

6.6 The Delphi licence proposal was approved by the NEB Board in July 1979 and the licence was executed the following month. The licence applied to "Delta II", which did not exist at that time but was intended to be developed by Delphi from Delta I using new hardware and for which new operating software would have to be written. Delta I was the only Delta machine in existence and was merely a working prototype, albeit in commercial use in a telephone answering system in San Francisco since 1977.

6.7 The licence agreement gave Nexos:—

(*a*) the exclusive right:—

(i) to manufacture the system in the UK;

(ii) to use or sell the system for office systems uses in Europe.

(*b*) the non-exclusive right to sell the system for all other uses in Europe.

6.8 Delphi undertook to provide Nexos with all the available technical information concerning Delta II within 90 days of Nexos requesting it, provided that Nexos' request came after the later of:—

(i) a purchase order for two Delta II systems, and

(ii) six months from the date of the agreement.

Failure by Nexos to order two Delta II systems within six months would have resulted in termination of the licence agreement.

6.9 In the licence Nexos agreed to pay Delphi an initial royalty of $2m plus an annual royalty for the next ten years based on the cost of any Delta II equipment manufactured by Nexos, subject to a minimum amount each year. The aggregate of the minimum royalties for the ten year period was $2.15m. In addition Nexos was obliged to spend a minimum of £1m before 1984 on the development of specific applications. The agreement also obliged Delphi and Nexos to disclose to each other improvements developed by them but the other party agreed to re-imburse half of the cost of developing the improvement if it wished to use it.

6.10 By the beginning of 1980 a number of changes had occurred in Nexos' perception of the Delta project. Nexos' development director concluded after a visit to Delphi that the product was not as ready as had been believed. He concluded that it was unrealistic to plan the first Delta machines for Nexos to do anything other than an installation very similar to what Delphi was doing in the USA, and that what Nexos therefore had to sell in the short term was a large telephone answering system manned by human operators. Even that required considerable work on "Europeanising" the system.

6.11 This analysis and change of objective appears to have been accepted within Nexos. The programme of objectives were thus modified to consist of Europeanisation and

plementation of a telephone answering service by April 1981 with various other telecom ilities being added in 1982. Document archive and other orginally envisaged functions h as voice recognition were put back to 1983, by which time there were also hopes to ve a lower priced version of the hardware available. However, these modified objectives re later seen to be optimistic.

.12 Dr Wilby explained to us that, although the licence agreement and the initial nce fee of $2m entitled Nexos to the Delta technology, in order to acquire this hnology it was necessary for Nexos to recruit a team to send to Delphi in California so t they might learn the technology. It was hoped that this team would then return to the after about six months bringing with them the requisite "know-how". Mr Moffat told hat their tasks were to learn the product in depth, to Anglicise the machine in order that ould inter-face with the British Telecom ("BT") network, to learn how to maintain the chine and to study how the machine could be built at lower cost by better component chasing and other value engineering.

.13 Dr Wilby told us that Delphi's Delta II was intended for a telephone answering vice in Los Angeles and that there was no possibility of Nexos acquiring a Delta machine il Delta II had been developed and was operating satisfactorily. Also, that the most ctical way for the Nexos team to learn the "know-how" was for it to become part of the lphi team developing Delta II. Accordingly, in 1980 Nexos recruited a team of some six seven software engineers who were sent to California for this task. Their costs were parently borne by Nexos without any recompense from Delphi.

.14 Nexos also recruited a Delta marketing team and during the first six months of 1980 s team appears to have had discussions with a number of large corporate bodies to define market requirements for a machine to be installed in customers premises as a telephone swering system.

.15 When Dr Wilby had visited Delphi in November 1979 it had been expected that the t Delta II would be operational by the end of July 1980. However, the development of lta II by Delphi took much longer than anticipated and does not seem to have been mpleted by the time Dr Wilby left Nexos in February 1981.

.16 By the middle of 1980 Nexos had recognised that the use of Delta for office systems s some way off, and unlikely to be achieved before 1983/84. Other ways of using Delta re therefore sought. The only feasible application in the short term appeared to be as a ephone answering system for which two possibilities were seen:—

(*a*) as an attachment to large customers' PABXs; and

(*b*) as a service bureau, probably in partnership with a telecoms authority.

.17 In August 1980 a joint Nexos/Delphi team studied alternative means of producing in-house telephone answering system with a view to defining the best solution for this ceived market. They concluded that "none of the concepts considered would give xos a marketable product for installation by July 1981".

.18 In parallel in 1980, discussions took place with BT with a view to setting up a ephone answering service bureau, as a joint venture between Nexos and BT, using the lta machine. Mr Moffat told us that in October 1980 BT agreed to the joint venture ject to confirmation of future financial support for Nexos. He said that following the cretary of State's decision in February 1981 to provide further funding for Nexos, there s a press leak in April 1981 of the proposed joint venture. This resulted in lobbying to the nister for Information Technology by industrial interests who felt threatened by the link ween two public sector bodies. He said that the Minister took the view that the proposed ture should not go ahead without private sector involvement. A merchant bank was refore instructed to obtain private sector participation. Mr Moffat told us that Nexos d BT worked with the merchant bank and a potential participant and were on the point of eement when the venture had to be abandoned as a result of the termination of the Delta nce in November on the instructions of the NEB. This followed the NEB's decision to -down the business of Nexos.

6.19 The first detailed business plan for Nexos' own application of Delta appears to have been produced in April 1981. This envisaged the first machines being delivered for "voicebank" (ie telephone answering service) applications in 1982, with progression to text and image applications by 1984. Orders for three systems were planned to be obtained in 1981, one of which was for the Nexos/BT joint venture.

6.20 When the Delta licence was terminated in November 1981, as part of the NEB instituted procedures for winding up Nexos, no Delta machines had been delivered by Nexos nor had it obtained any customer orders for any Delta systems.

7. DEVELOPMENT OF THE 2200 WORD PROCESSOR — BASIS AND TIMETABLE

This section outlines the background to the development of the 2200 word processor by Logica VTS for Nexos, the basis on which the development programme was undertaken, its timetable and the actual dates achieved. It also clarifies the position regarding the communication and automatic correspondence facilities of the machine.

Background

7.1 When the S&MA with Logica VTS was signed in January 1979, Logica VTS was already working on enhancements to the VTS 100. Although the S&MA was not signed until 26 January 1979, Nexos appears to have paid for development work on the VTS 100 from the end of September 1978; the records show the Nexos was, by agreement, invoiced an amount of £40,000 for work carried out by Logica VTS on the VTS 100 during the last quarter of 1978 together with the development expenses for the whole of January 1979.

7.2 Mr Moffat told us that by February 1979 he and an assistant had come to the view that the VTS 100 was inadequate for the market and that they would be unable to sell it in large volumes. During the spring of 1979 Nexos and Logica VTS had a number of discussions concerning development of word processing systems. These discussions were led on Nexos' side by Mr Moffat and an assistant (at that stage Dr Wilby, who became Nexos' Development Director, had not been recruited).

7.3 The initial idea appears to have been to produce quickly a new word processor derived from the VTS 100 but fairly closely based on it: the two systems were expected to have significant commonality of components and Nexos hoped to announce the new product in September 1979 and begin shipping it early in 1980. It appears that the VTS 100 software was intended to be useable on the new machine, since work was scheduled on enhancements to this software up to mid-1980, and Nexos continued to pay Logica VTS for development work. Nexos expected that manufacturing volumes of 200 to 300 systems a month of the new word processor would be required by early to mid-1980. In the interim Nexos would sell a repackaged version of the VTS 100, with a particular effort on the scientific version which commanded a higher price.

7.4 However, as the plans were refined a more sophisticated development programme emerged. The VTS 100 was based on an 8-bit processor. Nexos asked Logica VTS to base the new machine on the Intel 8086 processor, which was a new and more powerful 16-bit processor, for which Mr Hughes told us Logica VTS was one of the first customers in Europe.

The Development Plan

7.5 The definitive specification and development programme for the new machine (which became the Nexos 2200), were contained in a Development Plan and Cost Estimate dated 31 August 1979, presented by Logica VTS to Nexos. This substantial document set out a detailed plan for meeting Nexos' requirements. These were stated to be a pre-production batch of deliverable units by the end of June 1980 and production line systems from July 1980, together with five prototypes plus one spare for demonstration at the Hanover Fair in April 1980. The Development Plan contained detailed information about development milestones, dates and costs for the proposed development contract. In effect the document was a proposal by Logica VTS for carrying out the development programme described in it. The Development Plan stated that Logica VTS would have the discretion to

ploy on the programme sub-contract staff, including staff from other companies in the gica group.

.6 Under the S&MA development projects commissioned in the first two years were to charged to Nexos at cost plus a commercial profit margin to be agreed between the two ties. The document set out clearly and in some detail the financial basis on which it was posed this programme should be undertaken. In summary, the financial basis proposed s that Logica VTS would charge Nexos:—

(*a*) for individuals' time at half-daily charging rates. These rates were listed in the proposal and varied according to the seniority and skill of the people involved;

(*b*) for materials at cost to Logica VTS plus 15%;

(*c*) for use of equipment at depreciation plus 15%.

On this basis, the total development cost (excluding production and production tooling) s estimated in the document at £900,000.

.7 The document stated that the timescales required to satisfy Nexos' marketing uirements were exceptionally tight (underlining in original), and that a number of cial steps would be necessary to ensure milestones were met, including:—

— sacrificing functional requirements where their inclusion would jeopardise timescales;

— trading-off cost targets against timescales if necessary.

The document also stated that no cost or timescale contingency had been provided for.

7.8 It appears that this Development Plan was never formally accepted by Nexos, for isons which are not clear. This is notwithstanding that the document itself stated that ceptance of the plan and cost estimates should be in writing.

7.9 Nevertheless, Nexos let Logica VTS proceed with the development of the new word ocessor. This was confirmed by Nexos in a letter to Logica VTS of 30 November 1979 ting that Nexos approved the development plan in principle, that Logica VTS was uthorised for continuing funding as presented in the Development Plan of 31 August 79", and that this plan was "an acceptable basis for the release of funding as presented". owever, the letter went on to say that Nexos could not approve the document as a whole ce it appeared to imply a different relationship between the companies than that ntained in the S&MA.

7.10 To our knowledge this issue was never resolved. Nor have we found a statement of xos' views as to which terms of the development proposal were unacceptable, even ough Logica VTS asked for such a statement. However, at least part of the problem ems to have concerned Logica VTS' proposal to charge full commercial rates to Nexos for nsultancy provided to the project by staff from other parts of the Logica group.

METABLE AND ACTUAL DATES

7.11 Nevertheless, the two companies proceeded with the 2200 development according the Logica VTS plan, which showed production commencing in July 1980. Internally, xos was originally thinking of "launching" the product within the trade at the Hanover r (mid-April 1980), and this objective was maintained within the sales organisation up to end of February 1980. This suggests a period of at least 3 months between "launch" and t customer shipments ("FCS"). The likelihood of a slippage on the software part of the oject became clear to the Nexos development management during February and March 80.

7.12 At a meeting between Mr Moffat and the managing director of Logica VTS on 21 rch 1980 to discuss software timetables and launch plans they agreed to postpone the mal end-user launch until September. There were a number of reasons for the slippage, most readily identifiable being:—

— a decision to change the software structure to permit greater flexibility;

— difficulties with software development tools provided by Intel for the 8086 processor;

7.13 The Nexos records suggest that its Development Department and its sales organisation had differing understandings of the effect of the slippage in the development programme. It was the role of the Development Department to liaise with Logica VTS and, not surprisingly, that department appears to have had the more accurate understanding.

7.14 By 4 April 1980 the Development Department were working on the assumption that the milestones in the programme were as follows:—

Launch—first week in September;

FCS—first week in November.

However, within the sales organisation it appears that as late as June 1980 the first installations were expected in September. There is some lack of clarity in the records over what is meant by "launch" in this context. It appears to refer to the beginning of a publicity and sales campaign and is always in advance of delivery of finished machines to customers (FCS), but it is not clear what amount of time was envisaged as elapsing between launch and FCS. The date of delivery of a finished machine to a customer is the very earliest date on which the customer could have been invoiced for the sale.

7.15 The prototype machines intended for demonstration at the Hanover Fair in April 1980 were successfuly built and delivered by Logica VTS.

7.16 Between April 1980 and August 1980 the projected launch date of the beginning of September was held, but records of meetings in the Nexos Development Department show that it was recognised that the software part of the programme was critical and would cause delays in the launch if any slippage occurred. It had already been acknowledged by Nexos that the launch would occur without some features, such as automatic correspondence.

7.17 Production of the 2200 hardware began by Logica VTS as planned in July 1980. However, during early August 1980, it became clear to Nexos that it would no longer be possible to launch the product at the beginning of September because the necessary work on software had not been completed. In the event the launch took place in the middle of October 1980. Nexos' acceptance tests began on 5 November and "Beta site testing" (ie the release of machines to selected customers who agreed to participate in field trials in return for obtaining machines at concessionary rates) began in December. The first customer shipments actually took place in mid-January 1981.

7.18 Thus the actual launch was about six weeks later than the date agreed by Mr Moffat some seven months previously on 21 March; the FCS were ten to eleven weeks later than the date envisaged by the Development Department over nine months previously on 4 April.

7.19 During the course of this investigation it was suggested to us that a factor causing the relatively low level of sales of the 2200 in 1981 was that it lacked certain important features, or that Logica VTS were late in providing full features, or that the machine produced by them was in certain crucial respects not up to the agreed specification. I have therefore looked at the background to this.

7.20 It does appear that in December 1980, after the launch of the 2200 but before the first machines were shipped to commercial users, an assessement of the 2200 was performed by the Nexos marketing department which did suggest that the 2200 lacked competitiveness. The assessment was in fairly stark terms: "the conclusions of the Task Force were that the Nexos 2200 was deficient to such an extent that it would not achieve the volume of sales necessary to generate the expected revenue". However, the document ("Nexos 2200—Remedial Action: Short Term Plan, dated January 1981) admitted that the product met its specification. It appears therefore that either the marketing department had not attempted to assess how competitive the 2200 would be until the development was practically complete; or that by the time the product was ready, they had changed their minds about what features were necessary.

7.21 The result of this assessment by Nexos' staff was a programme of remedial action to the various deficiencies and provide enhancements as quickly as possible. Among the atures which had not been incorporated into the 2200 at the beginning of 1981 were mmunications and automatic correspondence facilities. An initial absence of these atures was said, during my investigation, to have been a particular factor in the low level 2200 sales. However, it appears that, at least as regards communications, the criticism velled at Logica VTS was largely without foundation.

OMMUNICATIONS

7.22 Communications is the term applied to a facility which allows machines to pass data etween each other. As applied to the 2200 it could mean any one of a range of facilities, cluding passing data to other 2200's, acting as a teletype terminal, or communicating with mputers using standard communciations "protocols". The original 2200 specification did ot include communications features, though it did make provision for a low speed mmunications channel in the hardware. An assessment of the 2200 specification carried ut for Nexos by consultants in December 1979 stated clearly that communications cilities were not included, and were to be developed later.

7.23 In July 1980 Nexos staff drew up a document setting out their ideas for the mmunication facilities the 2200 should offer. The document stated that at the April 1980 anover Fair Nexos had made statements to the effect that teletype and IBM 2780 rotocols would be available for customer shipment in April 1981. The document said that eeting this requirement was deemed essential and that informal (underlining in original) scussions with Logica indicated that these timetables were realisitic but that an early start as necessary.

7.24 It appears that work on these features was not commissioned by Nexos at that age. On 11 November 1980 Nexos' 2200 project manager wrote to Logica VTS to say that e was being urged by the Nexos marketing department to quote a date for mmunications availability and that he felt that while it might be desirable if a general mmunications philosophy were defined, in the short term a simple communications ackage could be provided separately. He asked Logica VTS to supply urgently a timescale nd cost estimate for a facility for basic 2200 to 2200 communication. It was agreed that this acility should be available from Logica VTS from June 1981.

7.25 More sophisticated communications using the IBM 2780 protocol were the subject a discussion at the Nexos Board meeting on 17 March 1981. There, Logica VTS were iticised because of the suggestion that such communication facilities would not be vailable until February 1982, and Mr Moffat is recorded as stating that increased cost was ow being faced by Nexos because the product did not appear to have been designed with mmunications in mind. This statement appears to relate to the fact that Logica VTS had then proposed a 2780 communications package involving fitting a specialised mmunications processor to the 2200 for an additional cost of goods of £100-£150. The evelopment work was proposed by Logica VTS on a fixed price basis for £183,000 with mpletion seven months from authorisation. Despite the comments at this Board meeting is clear that it was appreciated by Nexos' development staff that full communications cilities would not be available for some time and that it would require additional work. loreover, the letter of 11 November 1980 from Nexos' 2200 project manager to Logica Ts had conveyed the message that most customer enquiries could be satisfied by the rovision of the basic communications that could be implemented with the 2200's existing ardware.

7.26 The real problem appears to have been that the Nexos marketing department was repared to announce dates for the availability of communications without securing mmitments from Logica VTS or the Nexos development staff that the features would be vailable within that timescale.

UTOMATIC CORRESPONDENCE

7.27 Automatic correspondence ("AC") is the name given to a software feature that lows the automatic generation by the machine of a number of individual documents, awing on standard text and combining it with a list of variable items such as names and

addresses. AC features had been included as part of the original 2200 specification but when it became clear in February/March 1980 that Logica VTS would have difficulty meeting the full specification within the timetable, AC was marked down for separate, later release. When the 2200 was launched in mid-October 1980 a date of 1 April 1981 was announced for the availability of AC software. However, it appears that the final specification for the function was not agreed formally between Logica VTS and Nexos until 18 December 1980, though Logica VTS accepted a commitment to hand over the software to Nexos for acceptance testing by mid-March 1981.

7.28 Nexos took delivery of the AC software on 19 March 1981 but it appeared that some bugs remained in the software at that stage. Nexos' quality assurance staff accepted an AC software package on 30 April. However, there seems to have been a difference of view within Nexos as to its acceptability for release to customers, for although the quality assurance staff accepted it, product line management subsequently rejected it on the grounds that it contained faults which made it unacceptable for the market. A modified version was released by Nexos on 6 July.

Conclusion

7.29 It has been claimed that delay by Logica VTS in developing the 2200 and inadequate features in the machine supplied by Logica VTS was the reason for, or a major contributory factor in, the failure of Nexos. I consider this incorrect for the following reasons:—

— Firstly, for a project of this nature, the Nexos management should have recognised, and planned for, the possibility of unforeseen problems and the lack of any contingency margin resulting in the theoretical timetable not being adhered to.

— Secondly, the Nexos management had already built up a large sales organisation well before it could reasonably have expected to commence selling the 2200 in volume; furthermore the 2200's launch was only about six weks later than the date agreed by Mr Moffat some seven months previously and FCS were ten to eleven weeks later than the date envisaged by Nexo's development department over nine months previously.

— Thirdly, factors other than delay in the availability of the 2200 also contributed to the under utilised sales organisation. These factors included delay by Muirhead in getting its K442G T30 facsimile machine into production, the uncompetitiveness of that product when finally in the market-place and the low level of overall facsimile sales and Unicom sales achieved by Nexos.

— Fourthly, although in December 1980 Nexos' marketing department assessed the newly received 2200 as being deficient to such an extent it would not achieve the forecast sales, it admitted that the 2200 met its specification. This specification had evolved in discussion by Nexos with Logica VTS in the summer of 1979 and had been agreed by Nexos in the autumn of 1979.

8. RELATIONSHIP BETWEEN NEXOS AND LOGIC VTS

8.1 There has been much comment regarding problems in Nexos' relationship with Logica VTS and failures have been attributed to these problems. I therefore consider it important to understand the nature of the problems and to appreciate how they were viewed at the time. Accordingly this section traces, and comments upon, the relationship based mainly on Nexos' records.

1979

8.2 There appear to have been few problems of any significance during the first year of Nexos' operations; indeed, the documentary evidence suggests that the relationship between the two companies was progressing satisfactorily. The July 1979 Nexos Corporate Plan stated that apart from a hiatus in word processing sales by Logica VTS, "other aspects of the Logica VTS relationship are progresssing adequately". The conclusions of the NEB Executive Review of the Plan were slightly warmer: "Relations between Nexos and VTS are developing well".

3.3 The only issue it is possible to discern between the two companies at the end of 1979 ıcerned the precise contractual conditions governing the development of the 2200 word ›cessor. In a letter of 30 November 1979 approving the 2200 development programme in nciple, Nexos' systems architecture manager said that Nexos could not approve the ole of the Logica VTS Development Plan document because it appeared to imply a ferent relationship between the two companies to that contained in the S&MA. But xos appears not at that stage to have spelt out or attempted to resolve its objections to Development Plans contractual conditions.

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3.4 The first signs of any problems in the relationship appear in this period, although it is apparent from the contemporary documents whether these problems amounted to ything other than the normal issues that arise in any commercial relationship. The record a meeting of the Nexos Development Department in the middle of February 1980 ıtains the statement that "the (2200) development plan has some "commercial" content hich we have rejected) which does not gel with the S&MA. There is also an issue on ırge-out rates which is being investigated by J Wilkinson".

3.5 This latter reference is to Mr Wilkinson's concern, spelt out more explicitly in later cuments, about the appropriateness of some of the charges being made to Nexos by gica VTS for staff time. By mid-May, Mr Wilkinson had made a formal request for an dit of the charges being made by Logica VTS to Nexos for the 2200 development ›gramme.

3.6 In March 1980, a slippage in the 2200 development programme was declared and reed, but there is no indication in the documents that this caused any acrimony between companies at this stage.

3.7 In June 1980 certain NEB executives visited Nexos to discuss aspects of its financial rformance. A record of that meeting prepared by one of the NEB staff attributed some rly trenchant remarks to Mr Wilkinson concerning the performance and attitude of both uirhead and Logica.

3.8 Among the statements attributed to him in the note were "Nexos is now becoming ncerned that neither Logica nor Muirhead are commited to the Nexos plans, and in Mr lkinson's view, both companies are more committed to milking as much cash from xos as possible while the going is good", and "Mr Wilkinson believes (the 2200) velopment contract to be excessively favourable to Logica and the delay is working to gica's financial benefit." In retracting these comments at the time, Mr Wilkinson wrote the NEB saying that "there is no question in out minds of any lack of commitment by gica VTS to our plans". But in the light of our discussion with Mr Wilkinson we believe ıt the original note was probably a fairer reflection of the feeling then against Logica TS, at least on his part.

3.9 In the early part of July 1980 NEB executives conducted a review with Mr Moffat of Nexos July 1980 Corporate Plan. Contemporary documents suggested that while there re some difficulties in the relationship with Logica, Nexos (at least in the person of Mr ›ffat) took the view that none of the problems was incapable of resolution. The rporate Plan says that "the nature of the relationship with key suppliers has already monstrated Nexos' ability to get new products quickly to the market". Later, under the ading Key Supplier Relationships, it is stated "So far, in the case of Logica VTS this has ›ved effective in getting products developed very quickly, due to the discipline which ses from the separation of the two companies and the dedication of two management ms working in harness towards a common goal". There is no suggestion in the Corporate n that the relationship with Logica is other than satisfactory. However, it also states that ıe nature of (the supply and marketing) agreements means that the financial ısequences of any failures by the suppliers to achieve expense targets, project time scales product quality are borne by Nexos. This problem is particularly difficult at this early ge of the fast start up which Nexos is required to undertake."

8.10 The day after the NEB Executive Review Mr Moffat wrote to the NEB Chief Executive saying that "At our review with Sir Arthur Knight yesterday, we had a deal of discussion on the relationships between Nexos and its key suppliers. In thinking back over all the points covered, I feel that we spent so much time on the negative aspects that the positive points were almost completely lost. I therefore felt that I should state these briefly to you in order to ensure a balanced perspective". He then listed six positive features, and concluded by saying: " I do not seek to minimise the potential difficulties in these relationships and I assure you that we are well aware of the need for a management system which will contain these difficulties".

8.11 Logica VTS began production of the 2200 hardware in July 1980 and the project manager at Nexos sent a congratulatory letter to Logica VTS. In Mr Moffat's files is a copy of this letter on which Mr Hooton has written "DMM, I do not consider this appropriate". This appears to confirm what we have been told, that is the relationships between the two companies below the most senior levels were considerably better than the relationships between executive members of the two Boards. It also suggests that the difficulty in the relationships had begun before the real problems with the 2200 programme.

8.12 Thus I conclude that up to the beginning of July 1980, as far as Nexos and the NEB were concerned, there was recognition that the nature of the relationship between Nexos and Logica VTS had the potential for problems, that some problems had been encountered, but that what was required was the right approach to the management of the relationship rather than any fundamental change. On the other hand it does appear that some personality clashes were already occurring. The problems themselves seem to have centred on concern at the, perceived, lack of ability for Nexos to control costs incurred by suppliers. Nexos does not at that stage seem to have been greatly concerned at the slippage already declared in the 2200 development programme; rather, the programme was being cited as an example of how the nature of the relationship with key suppliers enabled Nexos to bring new products to the market quicker than would otherwise have been possible.

8.13 The relationship between the two companies appears to have entered a more difficult phase at the beginning of August 1980, when it became clear that the 2200 development programme had incurred further slippage. From 7 August onwards the correspondence between the companies at senior level was increasingly acrimonious. On 7 August Dr Wilby wrote to Mr Olson in the following terms:—

> ".....(Logica VTS') letter to me of 6 August is unacceptable. I can only assume it went out without your knowledge and approval and if you read it, you will see why I object to the tone and content. It reads like an attempt to set up an alibi in advance for late delivery by a group, supposedly expertly professional in software development, and also like an attempt to shift the blame for being late on to Nexos."

On 29 August, Mr Moffat wrote to Mr Olson:—

> "You are aware of the serious financial positions of Nexos resulting from the 2200 slippage..... The impact of the slippage means that any previous commitments on our part, which were matched to your commitments to us must be considered void. We now have to work closely together to find a way out of the problems."

8.14 Between August and October 1980, the independent review of Nexos was being conducted. The sections in the review document concerning the relationship between Nexos and its suppliers were prepared by Mr Dawson. The review document referred to disputes about financial arangements and said that some related to the start-up phase and some had been exacerbated by the 2200 delay combined with tight cash constraints imposed during the review process. It stated that all disputes appeared capable of resolution, but that two issues would always be present: financing of development projects and fixing transfer prices. It recommended that Nexos be asked to submit proposals on these issues.

8.15 When the NEB Board considered the review on 17 October 1980 they included among their conclusions that the NEB should seek as a matter of some urgency to resolve issues affecting Nexos' relationships with its suppliers. Possibly as a result of this, a document was prepared by Mr Wilkinson, dated 23 October, charting his view of the problems with Logica VTS and possible ways of resolving them. A number of options

ear to have been under consideration ranging from negotiation of amendments to the MA to the take over by Nexos of Logica VTS' operations.

GINNING OF 1981

.16 In early 1981 Nexos executive directors consulted Cazenove & Co about the sibility of attracting private sector funds into Nexos and as a result of advice received y appear then to have formed the view that a merger of Logica VTS and Nexos was the y logical way forward. Towards the end of January there was an exchange of respondence between Nexos and Logica VTS which Nexos appears to have believed ld be construed as Logica VTS serving notice on Nexos that it was in default of its igations under S&MA. Nexos accordingly instructed its solicitors to take Counsel's inion on whether it might be in default.

.17 Two weeks later, Counsels opinion was sought on the question of whether the perty rights in the 2200 belonged to Nexos or Logica VTS. The instructions to Counsel de it clear that Nexos' purpose in seeking the opinion was to establish that the property its in the 2200 belonged to Nexos and thereby strengthen their hand as regards a take r by Nexos of Logica VTS. However, Counsel's view, as expressed in conference, was avourable to Nexos, and therefore, following further instructions, an Opinion was duced which instead included the view that the S&MA was unworkable in important pects because it had been drafted unsatisfactorily.

.18 This was the background to certain of the executive directors of Nexos arguing in ruary 1981 to the NEB (and then by means of a letter addressed to Sir Keith Joseph) t the relationship with Logica VTS needed to be resolved through a merger with Nexos.

.19 The relationship between Nexos and Logica VTS does not appear to have proved once shipments of the 2200 word processor had got under way at the beginning of 81. The major issues between the companies during the next few months were the ability of the 2200's in service; the capabilities of the machine; and the transfer price and duction volumes.

LIABILITY OF THE 2200

.20 In March and April 1981 reports from the field suggested that 2200 machines had a h rate of failure. In reports to the NEB, Nexos said that in excess of 20% of machines re breaking down in service within a month, and this was suggested to be a contributory tor to the failure of sales of the 2200 to pick up. Logica VTS on the other hand argued at time that, at least in respect of the first month of operation, the true failure rate was just der 12%, with the balance being incidents in which no fault was found by a service gineer (eg operator error) or printers requiring adjustment. Furthermore, Logica VTS ued that the sample of machines on which this failure rate was found included 83% ich were built before the first customer shipment productions run, and were not refore representative of the quality of product coming off the production lines from d-January 1981 onwards.

PABILITIES OF THE 2200

.21 We have been told that in order to be properly competitive and achieve the dgeted sales volumes, the 2200 had to have two features which it initially lacked: nmunications capability and automatic correspondence. The relationship of these tures to the remainder of the 2200 development programme is discussed in Section 7.

.22 As indicated in paragraphs 7.22 to 7.26, it seems that the Nexos management uld have known that the 2200 would not have communications facilities in the first half 1981. The problems with availability of this feature seem to have been caused by Nexos' rketing department announcing dates for the availability of communications facilities hout first securing commitments from Logica VTS or Nexos development staff that the ture would be available within the timescale.

.23 Nexos had accepted by March 1980 that automatic correspondence would not be ilable on initial launch of the 2200 but had been expecting to have the software for this ture for acceptance testing by mid-March 1981. Following a difference of view within

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Nexos as to the acceptability of the software produced by Logica VTS, a modified version was released on 6 July 1981. The delay may have been a factor in the inadequate level of sales in the second quarter of 1981, and in the commentary on the May 1981 monthly financial return to the NEB, the disappointing level of UK sales of the 2200 was attributed by Nexos largely to the lack of a satisfactory automatic correspondence package.

TRANSFER PRICE AND PRODUCTION VOLUMES

8.24 At the time of signing the S&MA Logica VTS only had limited assembly facilities in Barnet, which Mr Hughes told us had been producing the VTS 100 at the rate of 200 p.a. To meet the volumes forecast by Nexos for the 2200, Logica VTS established production facilities in Swindon. Since the 2200 was the only product in volume manufacture at this factory there was a direct relationship between the number of machines produced for Nexos and the fixed costs that Logica VTS had to recover on each machine in the transfer price on the cost plus basis stipulated in the S&MA. At the relatively low levels at which the 2200 was selling in the first half of 1981 this had the consequences that the transfer price was very sensitive to the production volume, and that the fixed cost element was a large proportion of the transfer price. For example, in April, Logica VTS was prepared to offer Nexos fixed prices for 2200's on the following basis (the average selling price to UK customers during the first half of 1981 was £6,400):

Units over a six month period	*Transfer Price*
600	£3.625
1,000	£3,200
2,000	£3,060
3,000	£2,720

8.25 Nexos appeared to believe that Logica VTS had not made sufficient effort to reduce costs and told Logica VTS that even at the lowest rate during the first six months of 1981, Nexos would build up an inventory in excess of its requirements. On 9 March Mr Moffat accordingly told Mr Olson that Nexos wanted Logica VTS to produce the following quantities of 2200:–

Jan	*Feb*	*March*	*April*	*May*	*June*	*Total*
60	88	135	NIL	NIL	72	355

Mr Moffat told us that he attempted to turn off the supply of 2200s for a period during the first half of 1981 because Nexos had a month or so of inventory and wished to put Logica VTS into a weak position so that the NEB could force through a merger between Nexos and Logica VTS. However, a consequence was that Logica VTS felt obliged to adjust the transfer price to take account of the reduced production volume, and in the first quarter of 1981 charged in excess of £4,000 per unit to Nexos.

8.26 The persistence of the difficulties in the relationship between Nexos and Logica VTS led the NEB Board, at its meeting on 15 May 1981, to decide to seek direct NEB involvement in the management of both Nexos and Logica VTS. This was to help the NEB find practical solutions to the problems.

9. RELATIONSHIP WITH MUIRHEAD

This section outlines Nexos' relationship with its other key supplier, Muirhead, firstly in terms of sales of existing products and secondly in terms of the development of new products.

9.1 The NEB's concept of Nexos had been that it should be a marketing and development co-ordination organisation for a small number of companies possessing the key technologies and should be linked to these suppliers by exclusive supply and marketing agreements. In the event two such agreements were negotiated.

9.2 Paradoxically, because Nexos' only new product emerged from its relationship with Logica VTS much comment has been made which suggests that the relationship was unsatisfactory, but little corresponding comment has been made on the relationship with MOSL. I therefore felt it instructive to examine the relationship with MOSL to see how it functioned.

SITION ON SIGNING OF THE SUPPLY AND MARKETING AGREEMENT

9.3 The S&MA between Nexos and MOSL was signed at the end of September 1979. A rallel agreement had been signed two weeks earlier between MOSL and MDCL, which s a wholly-owned Muirhead subsidiary. A summary of the effects of these agreements pears in paragraph 5.31. Broadly, the intention was that MDCL would continue to be ponsible for the production of office facsimile product while MOSL would liaise with xos on the design and development of new products.

9.4 At that time the main product in the Muirhead office facsimile range was a machine own as the K442G. It had been on the market for a few years and was a general purpose simile transceiver (ie image transmitter and receiver combined). It was said to provide atively good copy quality but not to be very reliable or cheap to maintain. When it was signed the first international standard (known as CCITT Group 11) for facsimile chines had not been promulgated and it turned out that although in other ways mpatible with Group 11, the K442G did not incorporate a feature known as the T30 ndshake. Muirhead had therefore been working to develop a version of the K442G that uld include this feature, thereby making it fully Group 11 compatible. This machine was be known as the K442G T30, and when the S&MA was signed in September 1979 it was pected that volume deliveries would commence in March 1980. (It had originally been ended that the machine would be available earlier, but there were stated to be oduction problems due to the supply of components.)

9.5 The other machines in the Muirhead range, the K440 and K441, were respectively a nsmitter and receiver – ie similar to the K442G but each providing only one half of the ocess.

9.6 Shortly before Muirhead signed the S&MA, MDCL had concluded an agreement th Oki of Japan which gave it an exclusive European distributorship for a facsimile achine known as the Oki 6000. This was a machine new to the European market (indeed that time it did now have Post Office approval for connection to the telephone network) d was cheaper than the K442G although it was said to provide lower copy quality. It was ly Group 11 compatible.

ANSFER PRICES AND DELIVERY SCHEDULES

9.7 Like the S&MA between Nexos and Logica VTS, the MOSL S&MA did not provide specific transfer prices but merely stated a range within which Nexos and Muirhead re left to agree prices at intervals. However before signing the S&MA with MOSL, xos agreed provisional transfer prices for the first fifteen months for the existing oducts and for the K442G T30. This provisional agreement was recorded in a side-letter the S&MA which set out the number of each product expected to be ordered by Nexos d delivered to it, the transfer prices (to Nexos) and the end user prices on which these nsfer prices were based. In addition, documents annexed to the side-letter showed the sis on which the transfer prices were calculated and what profit or loss they implied for OSL. They showed the following prices:–

oduct	*Transfer Price*	*End User Price*
42G (new)	£3,350	£3,750
42G (refurbished)	£2,700	£3,500
42G T30	£3,250	£4,100
40	£2,000	£2,300
41	£2,000	£2,300
400 (Oki 6000)	£2,250	£3,000

9.8 These documents suggested that the cost to MOSL of the Oki machine was £1,450, l that it was anticipated that MOSL would make a negative margin (ie a loss) on its sales he K442G T30 to Nexos. Thus, MOSL was to receive a substantial margin on machines which it was simply a distributing agent in order to make up for losses on UK produced chines. However, these documents do not properly distinguish between MDCL and OSL and it seems that, in reality, MDCL received the margin on the Oki product.

9.9 Mr Moffat told us that the Nexos founders did not regard the fact that Muirhead's products were being overtaken by those of Japan as invalidating the Nexos concept. He said that facsimile technology was wanted by Nexos in order to develop its integrated office systems and the intention was that the margins on the Oki product would help keep MOSL going while it was undertaking its part of the Nexos development programme.

9.10 Under the S&MA Nexos was obliged to place orders for facsimile equipment with MOSL at nine monthly intervals for delivery in the period nine to eighteen months from the date of the order. This was because the lead time for manufacture of Muirhead products was stated to be nine months. Attached to the side letter to the S&MA was an agreed order schedule for the period up to the end of March 1981. It may be summarised as follows:–

	Number of Units			
Product	*79Q4*	*80 Q1 & Q2*	*80 Q3 & Q4*	*81 Q1*
K442G	32	30	0	0
K442G T30	0	185	240	155
K440	12	24	24	0
K441	12	24	24	0
K6400	80	335	360	240

9.11 At the transfer prices and end user prices shown, sales by Nexos of these quantities in the same period would have generated sales and gross profit figures for Nexos as follows:–

£K	*79Q4*	*80 Q1 & Q2*	*80 Q3 & Q4*
Sales	415	1,981	2,174
Cost of sales	335	1,539	1,686
Gross profit	80	442	488

9.12 This compares with figures of £5.1m given in the September 1978 NEB Paper as the forecast level of facsimile sales for 1979, which was then expected to be Nexos' first full year of operation, and £3.0m in 1978, which was the figure Muirhead's office facsimile sales were expected to reach in 1978.

Sales Achievement by Nexos

9.13 In the event no sales were achieved by Nexos in 1979 because the Muirhead sales force did not transfer to Nexos until January 1980. The actual level of sales in the first half of 1980 was only £328,000. This was 19% of the level anticipated in the order schedule, and 18% of the level anticipated in a detailed budget prepared by Nexos and filed with the NEB at the beginning of 1980. The level of sales in July, August and September was much better but declined steadily after September. Sales for the second half of 1980, at £1.2m were better than in the first half, though still well below expectations (53% of the level anticipated in the order schedule and 44% of the budgeted level).

9.14 The decline continued into 1981 and total facsimile sales for that year were £1m.

Reasons for the Lack of Facsimile Sales

9.15 During the first few months of 1980 orders for facsimile machines appear to have progressed reasonably well. Although cumulatively never up to the level of the budget, they were a significant proportion of it: by the end of April 1980 facsimile orders worth £1.15m. However, invoiced sales were at a low level in relation to orders: less than £300,000 at the end of April 1980.

9.16 The reason appears to have been that Muirhead had retained control of installations of the machines and also invoiced on Nexos' behalf. The resources devoted to installation and invoicing appear to have been inadequate and a large backlog built up. Under pressure from Nexos action was taken to remedy this and by the end of August 1980 the backlog appears substantially to have been cleared.

9.17 From September 1980 onwards, however, the trend of facsimile sales was downwards. It is not clear what the reasons for this were, but there were number of problems which were probably contributory factors.

9.18 Firstly, Muirhead was late getting the K442G T30 machine into production. Although at the time of the signing of the S&MA deliveries had been expected to commence in March 1980, it was not until September 1980 that the first deliveries were made to Nexos. Secondly, there appears to have been a question mark over the reliability of the machine. Apparently, the normal measure of reliability was the "mean time between failures" ("MTBF"). Nexos felt it could not sell the machine without quoting a figure for the MTBF and there was some difficulty in getting Muirhead's agreement that the quoted figure should be at least 250 hours. (This would mean that on average a machine would function for 250 hours before needing repair.) Thirdly, the copy quality of the K442G T30 was inferior to that of the K442G. All these factors led to Nexos believing that it was necessary to shorten an already very limited product life.

9.19 The Oki 6000, which was sold as the Nexos 6400, was itself not immune from problems, and it proved to be oversensitive to the quality of the telephone link.

9.20 However, Mr Moffat told us that while these operational problems did not help matters, he did not feel thery were of great significance in the overall Nexos story.

9.21 Because of the delay in the availability of the K442G T30, Nexos came to the view in the late summer of 1980 that MOSL should adjust the transfer price of the Oki 6000 to compensate Nexos for the loss of sales revenue and margin. The matter was raised at a meeting at the NEB in August 1980 chaired by Sir Arthur Knight. Following correspondence Muirhead conceded an adjustment to the price of the Oki 6000 in December 1980.

9.22 The main factor which caused the low level of facsimile sales in 1981 appears to have been changes in the market place, with the entry of other low cost Japanese suppliers. This development seems not to have been anticipated in the facsimile sales forecasts made in 1980.

9.23 The very low level of gross margin being achieved by Nexos on its facsimile sales may have led it to concentrate efforts on selling the 2200 word processor.

9.24 The S&MA between Nexos and MOSL required Nexos to order products from MOSL every 9 months for delivery in the following 9-18 months. I presume that this requirement together with the pattern of Nexos' facsimile sales are the reasons for the high level of Nexos' unsold stocks of facsimile machines when the decisions was taken in September 1981 to wind-down its business. I have not ascertained the quantity of machines included in the agreement signed in 1982 whereby these machines were acquired by MOSL but Nexos' records show that at 31 October 1981 it had unsold stocks of 878 units which had originally cost it £1.82m (as referred to in Appendix 12, paragraph 15).

Development Projects

9.25 Nexos commissioned a number of development projects from MOSL. The principal of these were called Avon and Tyne, although work was carried out or begun on a number of others such as technical evaluations of Oki facsimile machines and feasibility studies for other devices such as a mailroom scanner.

9.26 Avon and Tyne were code names for the elements of a system for the acquisition of facsimile images and for the storage of such images and their transmission to receiving devices when convenient. Avon was to be a facsimile device capable of scanning an A4 document in very few seconds and small enough to be placed on top of a desk. Tyne was to be the storage and forwarding system.

9.27 MOSL was asked by Nexos to proceed with the Avon project in March 1980 and the timetable targets at that time were to have available pre-production units by April 1981 and production units available from July 1981. The cost estimate submitted by MOSL on 28

February 1980 had been for a development cost of £83,000, but the work to be done by MOSL was initially to have the character of a feasibility study: Dr Wilby said in his letter of 4 March 1980 to MOSL that the project would be subject to a formal Nexos feasibility phase design review and a business review. If the decision were then to be not to proceed with project, Nexos would fund any work done on the project in the meantime. No other specific development contract or development terms were agreed between Nexos and MOSL at that stage: Dr Wilby's letter said simply that the project would be subject to the general terms and conditions of the S&MA.

9.28 The store and forward facsimile system project was reviewed by the Nexos Board in September 1980. In a letter of 18 September 1980, Dr Wilby informed MOSL that the proposal for the store and forward facsimile system had been approved, and that the decision had been made to go ahead with full funding with immediate effect, but to look for opportunities to reduce the 1980 cash requirement. The sums agreed for the two elements of the project were:

Avon £209,000
Tyne £499,000.

9.29 The bulk of the work on the Tyne project was software development and it was recognised that MOSL did not have the expertise for this work. Accordingly Scicon was chosen for it after a tender process in which Logica VTS had been among those to bid. Scicon acted as sub-contractors to MOSL.

9.30 The letter from Dr Wilby communicating approval of funding did not specify the precise basis on which the project was to go ahead. The details of the contractual terms and conditions were discussed between Nexos and MOSL over the next few months, while funding for the project was given on an interim basis pending the outcome of these negotiations. The conditions were finally agreed in March 1981.

9.31 The Tyne project seems to have turned out to be more difficult than anticipated. Notes of meetings in February 1981 state that while the Avon project was likely to be some £38,000 within the budget of £209,000, the Tyne project then looked as though it might escalate to £850,000, with completion not likely before August 1981 and, on pessimistic assumptions, possibly not before January 1982. (In the "milestones" agreed with the NEB in December 1980, the target had been to launch the finished product by the end of December 1981.)

9.32 The Avon and Tyne projects were cancelled at the end of October 1981 as part of the rundown of Nexos.

10. LETTERS SENT BY CERTAIN EXECUTIVE DIRECTORS TO SIR KEITH JOSEPH

10.1 It has been claimed that immediately before the meeting on 19 February 1981 between Sir Frederick Wood and Ministers the executive directors wrote to Sir Keith Joseph requesting him not to consent to additional funding for Nexos unless Nexos and Logica VTS were merged.

10.2 Mr Moffat told us that the executive directors considered there to be problems in the relationship with Logica VTS and that the most practical way to resolve those problems would be to bring Nexos and Logica VTS under common ownership. He said that they believed it essential that when the Secretary of State was considering the case for funding he should be fully aware of the problem with Logica VTS and that a merger with Logica VTS be a pre-condition for funding.

10.3 Mr Wilkinson and Mr Hooton appeared in a BBC2 "Money Programme" feature on Nexos broadcast on 27 Juanuary 1985. This programme stated that the executive directors sent Sir Keith Joseph a letter which, in essence, asked him not to give Nexos any more money unless the S&MAS were sorted out.

10.4 A two page letter dated 18 February 1981 signed by three of the four executive directors (Messrs Moffat, Wilkinson and Hooton) was sent to Sir Keith Joseph at the House of Commons. Attached to it was a five page letter dated 17 February 1981 addressed to Sir Keith Joseph by Mr Wilkinson. Also enclosed were two Counsel's Opinions running to 15 pages.

10.5 Copies of these letters are at Appendix 10. The letter signed by the directors stated six views that they considered Sir Keith Joseph should be aware of in considering the future of Nexos and it said that he should also be aware of the views of the finanacial director in the attached letter. One of the six views was that it was a prerequisite to private investment that there be merger of Logica VTS with Nexos, without which the executives could not recommend further funding, given the objective of achieving private sector investment. Their letter concluded by stating that it was written to ask for two things:—

(i) an urgent decision to provide up to a further £15m on the understanding that the directors would not seek more money;

(ii) his explicit support in insisting on a merger of Logica VTS and Nexos as an essential requirement in meeting a mutual objective of taking a successful company to the private sector.

10.6 The first Counsel's Opinion concerned amounts due by Nexos to Logica VTS. The second Counsel's Opinion concerned ownership of the rights in the design of the 2200 word processor and the contractual basis on which Logica VTS and Nexos were engaged in the production and marketing of the 2200 and similar equipment.

10.7 The letter from the Directors did not indicate any reason as to why they considered a merger of Nexos with Logica VTS to be a prerequisite to private sector funding. Mr Hooton explained to us that they had hoped the letter would provoke the Department into asking some searching questions.

10.8 The two letters were sent to the House of Commons and were not received at the Department until 19 February, after the meeting between Sir Frederick Wood and Ministers, referred to in paragraph 5.102, which had taken place at 9.00 am that morning. The letters were brought to the attention of the Secretary of State and Minster of State for Industry, who was responsible for the NEB.

10.9 The Department took the view that the letters were ill-judged. Also that they reflected a number of the observations made to Ministers that morning by Sir Frederick Wood, in particular the impact on morale of the uncertainty over Nexos' future and the difficulty of maintaining a credible trading position with the "drip-feed" funding approach. It was further felt that the letters indicated how welcome were Sir Frederick Wood's assurances that the new non-executive directors of Nexos would be examining the strength of its senior management.

10.10 The record of the meeting on 19 February 1981 is brief. Nevertheless, although there is no indication whether a merger was discussed, it does appear that the subjects of the other views stated by the directors in their letter were discussed, at least in general terms.

10.11 Letters were sent to Mr Moffat and Mr Wilkinson, under signature of the private secretary to the Secretary of State, thanking them for their letters and stating that the points raised were matters for the NEB and had been the subject of a meeting which the Chairman of the NEB had with Mr Tebbit and Mr Baker on 19 February. Copies of these letters are also at Appendix 10.

11. EXTENT OF THE DEPARTMENT'S KNOWLEDGE OF PROBLEMS IN RELATIONSHIP BETWEEN NEXOS AND ITS SUPPLIERS

This section indicates, in chronological order, the information in the files of the Department's Information Technology and Industrial and Commercial Policy "B" divisions which is relevant to the problems in Nexos' relationship with its suppliers.

11.1 Two parts of the Department were concerned with Nexos: Information Technology Division ("IT") had contracts with Nexos directly as it did with many companies in the industry; and Industrial and Commercial Policy Division "B" ("ICB") was responsible for relations with the NEB and had some knowledge of Nexos through its system of monitoring the NEB as a whole as well as particular information gathered when considering applications for statutory consent.

INFORMATION TECHNOLOGY DIVISION

11.2 During the course of 1979 and 1980 IT Division had several recorded contracts with Nexos staff. The discussions generally concerned Nexos' strategy and, in fairly general terms, how Nexos intended to implement the strategy. Of interest to IT was how Nexos' strategy fitted in with what was known of the plans of others in the field, its implications for the UK's trading position in Information Technology and the extent of possible collaboration between Nexos and other UK industrial undertakings in the information technology field.

11.3 Prior to receipt of a copy of the NEB's letter of 27 October 1980 conveying the outcome of the review of Nexos and seeking consent for increased funding there is no record in IT's files suggesting any difficulties between Nexos and its suppliers. Indeed, the same day as that letter was sent, most of the Board of Nexos were meeting officials of IT Division for a discussion, and the only recorded comments concerning the suppliers, attributed to Mr Moffat, were as follows:—

> "The Nexos 2200 which had been launched the previous week marked a useful step along the word processor path of the plan; the machine was ergonomically and environmentally an improvement on its competitors and had been well received."

and as regards Muirhead:—

> "The present Nexos facsimile machines were imported through Muirhead; Nexos had decided not to attempt to compete with the Japanese on the present level of machine but instead to concentrate their efforts on the development of a more advanced machine, with a store and forward facility . . . he expected this machine would be available in about one year's time."

11.4 On 12 November the Head of IT Division had a meeting with Mr Moffat at the latter's request: on 20 November there was to be a presentation of Nexos' Corporate Plan to officials of the Department, but the file note of the meeting said that Mr Moffat nevertheless wanted to provide a personal up-date on the situation. The note records the following points about Nexos' relationship with its suppliers.

> "There are still problems with suppliers—eg Logica (see below) and Moffat is clearly concerned about the delay in getting hold of 2200 word processor which has taken all revenue for this product out of 1980."
>
> and
>
> ". . . the greatest weakness seems likely to be in supplier relationships. As regards Muirhead, if this collapses, Moffat would propose to take over both the licences and Japanese products. But Logica VTS is another problem. Moffat claims that, because of bad management in Logica (eg in the ordering and supply of components), Nexos had had to bale out the Swindon operation temporarily to the tune of well over £1m and this has impacted his own cash flow. Nexos is heavily dependent upon Swindon producing the 2200 in 1981 in the right sort of quantity and Moffat says that he has put in some high-quality managers to help Logica. He clearly might want to think of buying out the VTS side of the business to protect this side of his operations."

11.5 IT Division's view of the perspective in which to place these problems can be inferred from contributions they made to the Department's consideration of whether, at the end of 1980, the NEB should continue to fund Nexos. They took the view that the main area of risk in Nexos' plans was that the software development required to adapt Delta to Nexos' requirements would take longer than estimated and that performance would fail to

reach targets. Four other areas of risk were identified, one of which was the continued ability of Nexos to control the product flow while it was not itself a manufactuer. This was stated to have led to difficulties already with the word processor.

INDUSTRIAL AND COMMERCIAL POLICY DIVISION "B"

11.6 ICB's knowledge of the relationship between Nexos and its suppliers before the autumn of 1980 was based on comments made on Nexos' progress in quarterly reports of the NEB's performance to the Department, and at meetings held to discuss these reports. The report for the first quarter of 1980 was received in the Department at the beginning of June. The report stated that Nexos had begun full scale trading in the quarter and that sales, at £0.9m, were lower than the budgeted £1.9m due to supply problems with Japanese Ricoh facsimile (SIC) machines. The report also said that Nexos launched its first new product at the Hanover Fair.

11.7 The report for the second quarter also showed Nexos' sales below budget and stated that this was due to the unavailability of the 2200 word processor, sales of which had been included in the 2nd quarter budget (SIC) , and to problems meeting the demand for facsimile machines.

11.8 The report for the third quarter of 1980 referred to delays with the 2200 word processor and T30 facsimile machine.

11.9 However, by the autumn of 1980 the rather limited information contained in the quarterly reports was being overtaken by more detailed material from the NEB sent to the Department in support of the request for consent to further funding for Nexos and in response to requests by the Department for information.

11.10 The letter of 27 October 1980 from the Secretary of the NEB which sought consent to an increase in funding to £35.2m, said that Nexos had suffered in the first year of its operation from the production difficulties of its major suppliers (Logica VTS and MOSL) . The accompanying letter of 28 October 1980 from Sir Arthur Knight referred to the NEB checking that satisfactory progress had been made in resolving a number of major issues including Nexos' relationship with its suppliers.

11.11 On 8 December 1980, Sir Arthur Knight wrote to the Secretary of State to urge a prompt decision on Nexos and among other comments said that its cash shortage was seriously damaging Nexos' relationships with its suppliers.

11.12 On 16 January 1981 Mr Moffat met Mr Baker. According to the record of the meeting Mr Baker emphasised Ministers' view that Nexos should attract funds from the private sector. Mr Moffat is recorded as welcoming private sector participation and possible partners, with whom discussions were being pursued, were reviewed. There is no suggestion in the record of the meeting that the relationship with Logica VTS would present an obstacle to such private sector participation or that Mr Moffat took the opportunity of the meeting to raise the matter of any fundamental problems in the relationship.

11.13 On 19 February 1981 the Department received the two letters written to Sir Keith Joseph by certain of the executive directors of Nexos. These letters are attached as Appendix 10 and have been summarised in Section 10. The principal letter requested Sir Keith Joseph's support for a merger of Nexos and Logica VTS on the grounds that this would be an essential requirement of taking a successful company to the private sector. There is no reference to any problems with the S&MA or in the working relationship between the two companies. Included in the accompanying five page letter from Mr Wilkinson were references to a dispute over amounts due to Logica and to Nexos suspecting that it may have been the intention of Logica to take every possible advantage from the S&MA.

11.14 The Department's assessment of the letters was that they were ill-judged; that they reflected a number of observations made by Sir Frederick Wood to Ministers earlier that day, particularly the impact on morale of the uncertainty over Nexos' future; and that

they also indicated how welcome were Sir Frederick's assurances that the new non-executive directors appointed by the NEB (Messrs Harris, Frost and Oakley) would be examining the strength of the company's senior management.

11.15 When the non-executive directors reported to the NEB in May 1981, there was more substantial discussion of the nature of the relationship between Nexos and Logica VTS. The Secretary of the NEB sent to the Department a report of the discussion at the NEB Board meeting which referred to the fact that the revised Nexos Corporate Plan stated that the company's S&MA with Logica VTS was very restrictive. It went on to say that after examining various ways of resolving the problems created by the S&MA (including renegotiation), the Plan suggested that the only practical solution to Nexos' difficulties with Logica VTS would be for the NEB to obtain a merger between the two companies. The report stated that Messrs Harris and Moffat claimed that Nexos had been let down persistently by cost over-runs and poor quality controls and that this was why Nexos considered a merger was vital rather than a re-negotiation of the S&MA.

11.16 The report went on to describe the view the NEB Board had taken of this, and reported Mr Hughes ' view that Nexos should be wound up and its assets transferred to Logica VTS. It stated that the next step agreed by the NEB Board was to gain Logica's acceptance of direct NEB involvement in the management of both Nexos and Logica VTS to help the NEB identify specific problems and find practical solutions. The NEB could then decide whether it would be better to seek a revised S&MA or a new corporate structure for Nexos and Logica VTS.

11.17 The Department's commentary on the NEB's report, includes the following "the unsatisfactory nature of the S&MA, in which there is no provision for termination or amendment, has long been recognised, but success with (any restructuring) will depend on the NEB's skill at negotiating, since Mr Hughes is, as he has made clear, in a very strong position."

11.18 In the record of a quarterly NEB monitoring meeting at the Department on 4 June, the Secretary of the NEB is recorded as saying that the major limitation in the Harris review was that it had been able to assess the Nexos relationship with Logica only from the point of view of Nexos and that the next step was for an NEB executive to consider the relationship by talking to both.

11.19 On 2 July 1981 the Secretary of the NEB wrote to ICB to report this executive's preliminary conclusions: that he had sought a short-term improvement in the relationship between Nexos and Logica VTS and the relations between the two companies were now better at working level , though in the medium term it would be necessary to establish a new formal relationship within which Logica VTS and Nexos could operate.

12 NEB MONITORING OF NEXOS

This section describes the NEB's monitoring of Nexos, comments on certain aspects and indicates some of the information received by the NEB from Nexos.

12.1 Although the NEB's policy with regard to representation on the Nexos Board changed in 1980 there appear to have been three basic strands to the NEB's approach to its monitoring of Nexos. Firstly, designated NEB staff members monitored Nexos, secondly it received a monthly financial return in a standard NEB format and thirdly, it reviewed Nexos' annual corporate plans.

Monitoring by NEB Staff and Board Representation

12.2 Mr Willott told us that he understood that the philosophy of the NEB under the Board of which Sir Leslie Murphy was chairman had been that those who made the investments were the ones to act as the primary monitors, since they had the motivation to make the investment succeed and detailed knowledge of the company and its management. Generally the monitoring officer had been on the board of the company. He said that the external objective element had been brought in by the close involvement of both the executive Chairman and the executive Deputy Chairman in the NEB's day to day affairs.

12.3 Sir Leslie Murphy was both Chairman and Chief Executive of the NEB until November 1979 when he and the other members of the NEB resigned.

12.4 The divisional director of the NEB's Division B, which had conceived the idea of and created Nexos, was Mr Dunbar. He had steered the Nexos proposal through the NEB Board and had been closely involved in setting-up Nexos and in recruiting Mr Moffat. Mr Dunbar was Chairman of Nexos from its formation until October 1979 when he left the NEB. The chair was then taken by the NEB Deputy Chairman for a few weeks until he resigned as a member of the NEB.

12.5 When Mr Dunbar left the NEB its role under the new Government was changing in consequence of which he was not replaced, and Mr Dawson took over his position as Head of Division B. Mr Dawson was also a director of Nexos from its formation until early in 1981 when he left the NEB. Mr Dawson was the staff member of the NEB s Division B who had been closely involved in the development of the Nexos idea, in negotiating the S&MAs and in setting up Nexos.

12.6 As mentioned above, the advantage of having as monitoring officer someone who has been involved in establishing a venture is that such a person has the motivation to make it succeed. The disadvantage is that adverse reports by him to the NEB may reflect adversely on him because he may be seen to have had some responsibility for the concept and creation of the venture. There are also different views as to whether the monitoring officer should be on the Board of the company. Membership of the Board may in practice be the most effective way of obtaining access to the necessary information. However, membership of the Board carries responsibility for the company's business and this may conflict with the need, as an employee of the NEB, to take a detached view of its progress.

12.7 Mr Willott told us that under the NEB Board of which Sir Arthur Knight was chairman the emphasis changed from leaving the bulk of the management to be carried out by NEB staff to putting more responsibility into the hands of trusted external non-executive directors who were put on the boards of NEB companies. Under this approach the NEB had a separate monitoring officer.

12.8 Mr Willott also told us that in the summer of 1980 Sir Arthur Knight restructured the NEB so that different divisions dealt with new investment on the one hand and management of the existing investment portfolio on the other hand. Within the latter division Mr Dawson continued to monitor the former Division B's investments. However, it was not until February 1981 that the NEB was able to find three external non-executive directors to appoint to the Nexos Board.

Monthly Financial Return

12.9 Nexos sent the NEB a monthly financial return in the standard NEB format. In particular the return showed actual and budget figures on a monthly and cumulative basis for trading results (including orders accepted, sales made, gross profit, and overheads), assets and liabilities and sources and applications of funds. The return also showed the number of staff at the month end. This return was submitted for all months from the beginning of 1980.

12.10 During 1979 Nexos provided the NEB with monthly financial information in differing forms which, in view of the more limited nature of Nexos' activities in that year, was adequate for the purposes of financial monitoring .

12.11 Prior to July 1980 the monthly financial returns were sent to the NEB's Finance Department who copied them to Division B. It seems that the returns were not subjected to a critical review by the Finance Department but merely summarised for presentation monthly to the NEB Board. In this period the monthly financial returns were reviewed by Division B and I understand that, at least for part of the period to mid-1980, the division's staff included an accountant.

12.12 We have been told by the secretary of the NEB that all or substantially all of the regular monitoring information should have been available to Sir Leslie Murphy, his

executive Deputy Chairman and to the finance director. The finance director provided the senior management with a "second line of advice" on the performance of companies. He also had specialist monitoring accountants on his staff responsible for helping companies to institute monitoring information systems .

12.13 In July 1980 the NEB decided to commission the independent review and asked Nexos to keep within a funding limit of £15.8m until the end of 1980. As a result, although the previous procedures continued, from July the NEB finance director reviewed the monthly financial returns and monitored Nexos' cash requirements.

12.14 In December 1980 the procedures were amended and Nexos was instructed to send its monthly financial returns to Division B. However, by that date Nexos was in financial difficulties, its continued existence was uncertain, and as a result it was being closely monitored by the NEB.

12.15 As explained in section 5 of this report, following approval of the October 1980 Corporate Plan, at the end of 1980 the NEB agreed certain performance "milestones" for 1981 with Nexos as a means for measuring Nexos' progress against the Plan. The Nexos management sent the NEB a commentary with the monthly financial returns which showed how performance compared with these milestones.

12.16 In addition to the standard NEB format monthly financial return Nexos' full internal monthly management accounts were sent to the NEB during 1981, as well as a rolling three monthly cash flow forecast. From February onwards weekly "flash" reports of sales and orders were also sent so that the NEB could closely monitor the way sales were progressing.

12.17 I have reviewed the monthly financial returns for the first six months of 1980 to see if they give any indication of the rapid build up in the level of on-going expenditure that was taking place. With the exception of the increase in staff numbers referred to below, they do not do so. The budget figures, with which "actual" figures are compared, are based on an annual budget drawn up by Nexos at the beginning of 1980. This budget had been submitted to the NEB and approved by Mr Dawson but it is not clear to what extent it was endorsed by the NEB. Officially the NEB had approved the five year financial forecast in the July 1979 Corporate Plan. But this had been drawn up before Nexos had really commenced operations; six months later it would have been sensible for Nexos to draw up a new budget, at least for its own internal use.

12.18 These monthly returns show turnover to be substantially below budget. Monthly overheads were both below and above budget but cumulatively were below budget and the cumulative loss was never significantly above budget. It is therefore not surprising to see that the NEB's attention appears to have been focused on the substantial shortfall in sales.

12.19 Two specific reasons were given for this shortfall and the impression was that Nexos was "taking-off" more slowly than envisaged in the budget. Despite this, its management were embarking on actions which led to a rapid build-up in the level of out-goings. This was not apparent from the monthly financial returns for the first seven months of 1980. The reason is simply that in the first few months the effect of increasing the rate of expenditure was insufficient in that month, or in the context of cumulative figures, to provide any warning of the serious problem that was building-up. By the time this might have been detected from the monthly returns the NEB had already instituted the independent review following its consideration of the July 1980 Corporate Plan.

12.20 Month end staff numbers and budgeted staff numbers for the end of 1980 were shown in the monthly financial returns to the NEB. The rapid build up in staff numbers by Nexos would have been apparent from an examination of these returns; indeed, the number budgeted for the end of the year had been exceeded by the end of July. However, by this time the NEB had already instituted the independent review of the July 1980 corporate plan.

REVIEW OF THE CORPORATE PLANS

12.21 The NEB reviewed the July 1979 and July 1980 Nexos corporate plans. Failure to endorse the latter plan led to the independent review of Nexos which resulted in an amended corporate plan dated October 1980. This plan together with the results of the independent review were considered by the NEB Board and are referred to in paragraphs 5.68 to 5.74 and described in more detail in Appendix 9. Following the appointment by the NEB of three non-executive directors to the Board of Nexos, the resulting Plan was considered by the NEB Board in May 1981.

OTHER ASPECTS OF MONITORING

12.22 Another element in the NEB's monitoring of Nexos was its internal discussion of information regarding Nexos and its resultant decisions.

12.23 It is difficult to piece together from the NEB's files a precise record of the various discussions regarding Nexos which took place within the NEB, and between the NEB and third parties, in the crucial period to mid-1980. I have been told that the management style of the NEB followed that of private sector companies and involved a great deal of informal consultation between staff with relatively few matters being committed to paper in internal communications or records. It also reflected the management styles of its various chairmen and chief executives. There were four chairmen and three chief executives over the three years 1979, 1980 and 1981.

12.24 Until November 1979 monitoring of Nexos appears to have relied substantially on personal contacts and oral reports and discussions. It is not therefore easy to ascertain from the records the extent to which the changes in direction of Nexos, when compared with the proposals in the September 1978 NEB Board Paper, were recognised, discussed or approved. Nevertheless it is clear that Sir Leslie Murphy knew of the delays in concluding the Muirhead agreements because he was involved in crucial meetings in this regard.

12.25 Sir Arthur Knight became NEB Chairman in November 1979 following which a system of formal quarterly reviews of each division's investments was instituted. In addition Sir Arthur Knight initiated an overall review of the NEB's strategy and a programme of reviews by the Board of each of the NEB's major investments, of which Nexos was regarded as one.

12.26 After Mr I Halliday became NEB Chief Executive in February 1980 monthly situation reports on Nexos were made to him by Mr Dawson and these were copied to the NEB's finance department/director. These reports were generally brief, giving an indication of how turnover and losses compared with budget, together with a brief explanation of variances. It was appreciated that Nexos'sales were well below budget in the first part of 1980 and the reasons given were supply problems with Ricoh products and a back-log on installations of facsimile machines. The level of overheads was not commented on in these situation reports, nor could it be ascertained from the format of the quarterly review reports sent to the Chairman.

12.27 Overheads were referred to in a commentary prepared by Mr Dawson in May 1980 on the revised Nexos 1980 budget. This took the form of a memo to Mr Halliday (not copied to the finance department) showing how the revised 1980 budget differed in its financial implications from the corporate plan approved by the NEB Board in July 1979. It stated that the level of budgeted overheads was above that justified by the prospective 1980 turnover and suggested that this was necessary to allow the management to cope with the rapid growth and higher turnover subsequently expected.

12.28 In the context of clarifying the extent to which the NEB were aware of and concurred with the build-up of Nexos staff numbers in 1980 Mr Dawson told us that the NEB's computer division was stretched to breaking point at that time. He said this was because NEB staff had been lost and could not be replaced and the pressure on everyone was enormous. He felt that the NEB's resources had been adequate at the time Nexos was established but not by this stage of Nexos' development. In his view this arose because of a combination of the NEB's investments becoming more demanding and pressures on NEB resources; the latter being partly due to staff shortages but also because of the extra load in

reviews by the new NEB Board, the new divestment policy and problems caused by cut backs in several NEB subsidiaries. He told us that, because of the NEB's uncertain future role, it was unable to recruit additional staff to assist in managing its investments.

13 CONCLUSION

Perhaps the final irony of the Nexos story is that this report, with its numerous drafts , has been produced on an ICL-badge model of the 2200 word processor.

R A FORD

June 1985

APPENDIX 1

FINANCIAL AND STAFF PROFILE OF NEXOS

Date	*Amount Approved by NEB Board for NEB to invest in Nexos—£K*	*Amount Authorised by DoI for NEB to Invest in Nexos—£K*	*Amount Invested by NEB in Nexos*		*Cash Spent by Nexos (Net of Receipts)*		*Staff Numbers of Nexos at End of Month*
			In Month £K	*Cumulative £K*	*In Month £K*	*Cumulative £K*	
1978	15,000	15,000	—	—	—	—	—
1979:							
January			—	—	—	—	*
February			—	—	2	2	*
March			—	—	37	39	*
April			—	—	47	86	*
May			250	250	165	251	*
June			443	693	93	344	*
July	+5,000		—	693	320	664	*
August			900	1,593	823	1,487	*
September			900	2,493	133	1,620	*
October			300	2,793	1,112	2,732	*
November			1,300	4,093	477	3,209	*
December			—	4,093	370	3,579	144
1980:							
January			2,300	6,393	1,198	4,777	170
February			—	6,393	775	5,552	224
March			3,000	9,393	729	6,281	248
April			—	9,393	977	7,258	273
May			—	9,393	1,295	8,553	298
June			—	9,393	324	8,877	307
July	−4,200	+800	1,500	10,893	1,585	10,462	323
August			1,000	11,893	1,153	11,615	333
September			2,000	13,893	1,724	13,339	363
October	+12,000		1,000	14,893	1,039	14,378	383
November			907	15,800	928	15,306	408
December		+5,300	1,000	16,800	972	16,278	405

[Continued

APPENDIX 1 (cont)

FINANCIAL AND STAFF PROFILE OF NEXOS

Date	*Amount Approved by NEB Board for NEB to invest in Nexos—£K*	*Amount Authorised by DoI for NEB to Invest in Nexos—£K*	*Amount Invested by NEB in Nexos*		*Cash Spent by Nexos (Net of Receipts)*		*Staff Numbers of Nexos at End of Month*
			In Month £K	*Cumulative* £K	*In Month* £K	*Cumulative* £K	
1981:							
January		+1,000	2,650	19,450	1,994	18,272	410
February		+13,000	1,100	20,550	890	19,162	398
March	+7,300		2,000	22,550	1,388	20,550	387
April			1,150	23,700	1,621	22,171	371
May			1,350	25,050	1,721	23,892	371
June			1,300	26,350	882	24,774	372
July			1,200	27,550	1,043	25,817	364
August			1,000	28,550	1,410	27,227	340
September			—	28,550	607	27,834	334
October			1,000	29,550	569	28,403	322
November			—	29,550	688	29,091	279
December			500	30,050	513	29,604	250
1982 (in total)			1,693	31,743	1,900	31,504	

Footnotes:

1. In addition to the money invested by the NEB, the four executive directors of Nexos and a senior member of management invested £6,300 in Nexos under the share incentive arrangements.
2. * = Information not readily available.

APPENDIX 2

AMOUNT OF THE NEB'S LOSS ON NEXOS

The final amount of the NEB's loss is not yet known because the liquidation of the Nexos companies is not complete. The latest estimate by the British Technology Group of the NEB's loss is £24.4m, made up as follows:—

	£M
NEB money invested in Nexos up to 18 September 1981, when the NEB effectively decided to terminate Nexos:—	
Cost of shares in Nexos (NOSH and NOSL)	28.550
NEB money put into Nexos after 18 September 1981, initially to preserve core of the business during sale negotiations and subsequently in order to pay-off liabilities and meet the expenses of the winding-down phase:—	
Loans to Nexos	1.500
Cost of shares in Nexos (NOSL)	1.693
Amount invested by NEB in Nexos – per Appendix 1, column 4	31.743
Payment on behalf of Nexos as part of the NEB's negotiated settlement of Nexos' financial obligations to Logica VTS	0.250
Total cash put into Nexos by NEB	31.993
Winding-down expenses paid directly by the NEB	0.056
	32,049
Less: Estimated benefit to the NEB and its subsidiaries from the utilisation of Nexos' tax losses	7.652
Estimated loss by the NEB on its investment in Nexos	24.397

Footnotes:

1. The estimated loss takes no account of any amount which the NEB may receive from the joint liquidators on completion of the liquidation of the Nexos companies.
2. The accounts of the NEB for the year ended 31 December 1981 included a provision of £34m against its investment in Nexos and for liabilities of Nexos. The excess of this provision over the amount of the NEB's loss will be credited in the NEB's accounts after completion of the liquidation when the amount of the loss has been finally determined.

APPENDIX 3

WHERE THE MONEY WENT

1. I have attempted to show where the money put into Nexos by the NEB went to and in so doing have identified the headings I regard as relevant for this purpose in the context of this report. As is usual, the monthly management accounts of Nexos and its annual financial accounts were prepared to meet other objectives. The following summary has been deduced by me from information pieced together from the (unaudited) management accounts and supporting papers supplemented by the (audited) financial accounts and other sources. It has not proved practicable to prepare a wholly accurate summary because of various limitations in the source information. Nevertheless I consider the following summary provides a good indication of how the money was spent.

2. For practical purposes I have regarded the 18 September 1981 NEB Board decision to run down the business of Nexos as being when the NEB decided to terminate the Nexos venture. Therefore, in showing where the money went, I deal separately with the period to the end of August 1981 and the subsequent period. This latter period reflects both the disposal and the termination of the various parts of the business and the NEB's provision of sufficient funds for Nexos to pay its liabilities in full. This practice was in accordance with the NEB's then interpretation of The National Enterprise Board (Guidelines) Direction 1980. The relevant part of this Direction stated that "in deciding on their practice in realtion to the debts of their subsidiaries, the Board shall have regard to the practice of companies in the private sector in relation to the debts of their subsidiaries."

Cash Spent to End August 1981	*Footnote*	£K	£K	£K
Central Management and Head Office Costs (of NOSL)	(a)			3,866
Acquisition or Establishment, and Build-up of Sales Organisations:				
Acquisition and build-up of UK sales organisation (UDS/NUKL)	(b)		5,421	
Establishment and build-up of a sales organisation in Ireland	(c)		369	
Establishment and build-up of a sales organisation in W Germany	(d)		834	
				6,624
Development Activities:				
Nexos Development Department running costs (including 1980 costs of Nexos Delta development team)			830	
Delta (see above)	(e)		2,439	
Paid for External Development Work:—				
To Logica VTS for 2200 word processor (includes small amount for VTS 100 in 1979)	(f)	2,628		
To Logica VTS for Tornado study		119		
To Logica VTS for other work		285		
To MOSL and Scicon for decentralized scanner and store and forward facsimile		844		
To other parties for other projects		173		
			4,049	
				7,318
Build-up of Stocks:				
Muirhead facsimile products			1,543	
Logica VTS word processing products			711	
All stocks, in 1981 (analysis not available but largely Muirhead facsimile and Logica VTS 2200 word processor products)			1,994	
				4,248
Trading Loss (in UK) after Commencement of 2200 word processor sales	(g)			1,490
To Logica VTS for Start-up Manufacturing Costs of 2200 word processor				702
To Logica VTS for Purchase of Unicom Sales Rights				500
To Logica VTS for Other Payments				231
Purchase of Cars and Office Equipment, Fixtures and Fittings by NOSL (net of proceeds of sale and leaseback of cars)				536
Urwick-Nexos	(h)			328
Nexos European Marketing Department – running costs				323
Consultancy Fees in 1979				200
Increase in Working Capital of NOSL				754
Miscellaneous and Unanalysed Items				414
				27,534
Less: Interest received by Nexos on NEB funding prior to spending it				307
CASH SPENT TO END AUGUST 1981				27,227

Footnotes	£K	£K
(a) 1979		819
1980		1,483
1981, to end August		1,564
		3,866
(b) Comprises cash cost of building-up NUKL (including "excess" overheads to end December 1980, when the 2200 word processor became available to sell):—		
Cost of UDS in 1979		890
Purchase of fixed assets (net of proceeds of sale and leaseback of cars)		658
Increase in working capital (excluding stocks of Muirhead and Logica products)		711
Net trading deficit in remainder of 1979		47
Overheads in 1980	4,589	
Less: Gross profit in 1980	1,474	
		3,115
		5,421
(c) Nexos Office Systems (Ireland) Ltd		
Purchase of fixed assets		24
Increase in working capital (excluding stocks)		149
Overheads	324	
Less: Gross Profit	128	
		196
		369
(d) Nexos GmbH		
Pre-incorporation costs by NOSL		43
Purchase of fixed assets		27
Increase in working capital (excluding stocks)		156
Overheads	698	
Less— Gross profit	90	
		608
		834
(e) Initial licence fee		898
Prepayment for Delta II order		709
Delta marketing team running costs, 1980		253
Delta project team running costs, 1981 to end August		575
External development work		4
		2,439
(f) 1979 (includes small amount for VTS 100)		703
1980		1,173
1981, to end August		752
		2,628

These amounts do not compare with the 31 August 1979 cost estimate by Logica VTS as they include other work subsequently requested by Nexos.

(g) NUKL trading loss in 1981 to end August	
Overheads	3,113
Less: Gross profit	1,623
Trading Loss	1,490

(h) Urwick-Nexos Ltd		
Purchase of fixed assets		73
Trading loss		347
		420
Less: Increase in creditors		92
		328
Cash Spent from September 1981 to End December 1982	*£K*	*£K*
Paid for External Development Work:—		
2200 word processor	295	
Facsimile	279	
Other projects	16	
		590
Nexos' Delta project team		119
Termination of Delta project		204
Head Office costs and trading losses in UK, Ireland and W. Germany		3,584
Redundancy, termination and closure costs and unanalysed items		2,837
		7,334
Less: Sales of 2200 word processor to ICL,	2,767	
Sale of service business, including stock	190	
Sale of Nexos Office Systems (Ireland) Ltd	100	
		3,057
CASH SPENT FROM SEPTEMBER 1981 TO END DECEMBER 1982		4,277
Summary:		
Cash Spent to end August 1981		27,227
Cash Spent from September 1981 to end December 1982		4,277
Total Cash Spent to end 1982 – per Appendix 1, column 6		31,504
Reconciliation:—		
Amount invested by NEB in Nexos – per Appendix 1, column 4	31,743	
Amount invested in Nexos under share incentive arrangements – see Appendix 1, footnote 1	6	
		31,749
Payment by NEB to Logica VTS as part of the NEB's negotiated settlement of Nexos' financial obligations to Logica VTS		250
		31,999
Less: Cash spent by Nexos to end 1982 – as above		31,504
Cash and Bank Balances of Nexos at 31 December 1982		495

NOSL, NUKL and Nexos Leasing Ltd were put into liquidation on 31 May 1983. At 31 January 1985 the joint-liquidators held bank balances of £847,906.

APPENDIX 4

THE POWERS OF THE NEB UNDER THE INDUSTRY ACT 1975 AND THE ARRANGEMENTS THEN IN FORCE FOR ITS SUPERVISION BY THE DEPARTMENT

1. The National Enterprise Board ("NEB") was established by the Industry Act 1975 ("IA'75") as a body corporate (a statutory corporation) to consist of a Chairman and between 8 and 16 other members.

2. The functions of the NEB (as provided by the IA'75) were:—

(*a*) establishing, maintaining or developing, or promoting or assisting the establishment, maintenance or development of any industrial undertaking;

(*b*) promoting or assisting the re-organisation or development of an industry or any undertaking in an industry;

(*c*) extending public ownership into profitable areas of manufacturing industry;

(*d*) promoting industrial democracy in undertakings which the NEB control; and

(*e*) taking over publicly owned securities and other publicly owned property, and holding and managing securities and property which are taken over.

In addition, the NEB could do anything to facilitate the discharge of these functions, or which was incidental to them or was conducive to their discharge.

3. The purposes for which the NEB could exercise its functions were:—

(a) the development or assistance of the economy of the United Kingdom or any part of the United Kingdom;

(*b*) the promotion in any part of the UK of industrial efficiency and international competitiveness; and

(*c*) the provision, maintenance or safeguarding of productive employment in any part of the United Kingdom.

4. In particular the NEB had the power to:—

(*a*) acquire, hold and dispose of securities;

(*b*) form bodies corporate;

(*c*) form partnerships with other persons;

(*d*) make loans;

(*e*) guarantee obligations (arising out of loans or otherwise) incurred by other persons;

(*f*) acquire and dispose of land, premises, plant, machinery and equipment and other property;

(*g*) make land, premises, plant, machinery and equipment and other property available for use by other persons; and

(*h*) provide services in relation to finance, management, administration or organisation of industry.

5. In addition,

(*a*) Section 7 of the IA'75 provided that the Secretary of State could give the NEB general or specific directions as to the exercise of their functions;

(*b*) Section 10 of the IA'75 provided that acquisitions by the NEB (or by its subsidiaries) of share capital in a company which:

either took the NEB's voting control of the company over 30%;

or took the cost of the NEB's shareholding over £10m;

required the prior consent of the Secretary of State.

(*c*) Section 6 of the IA'75 provided that it be the duty of the Secretary of State to determine the financial duties of the NEB (and that in so doing it was the duty of

the Secretary of State to satisfy himself that any financial duties so imposed were likely, taken together, to result in an adequate return on the capital employed by the NEB).

6. The Secretary of State gave the NEB a Direction as to the exercise of its functions, pursuant to Section 7 of IA'75 (called "The National Enterprise Board (Guidelines) Direction 1976").

(*a*) This Direction, inter alia, permitted the NEB to make loans, provide guarantees, engage in joint ventures or make any other form of financial commitment within a limit of £25m for each project, and required the NEB to act only with the approval of the Secretary of State where the amount exceeded £25m. In all cases where a proposed commitment exceeded £10m or raised new or significant policy issues, the NEB were required to give the Secretary of State reasonable notice of their intentions and to wait for a reasonable time before acting;

(*b*) The explanatory notes to the Direction indicated that the general approach was that the success of the NEB depended on the NEB having a large measure of operational and commercial freedom and that;

(i) the Government's oversight would be exercised so far as possible through long-term strategies to be reflected annually in the preparation of medium-term investment plans and year by year budgets; and

(ii) the Government's procedures for assessing the NEB's performance would be clearly defined and would avoid frequent or detailed enquiries.

The explanatory notes also stated that the Government would settle with the NEB a framework of objectives and strategy to give effect to the purposes and functions which were set out in the IA'75, with particular reference to the NEB's role in encouraging industrial efficiency, promoting employment and improving the balance of payments, with special regard to export opportunities. The NEB's strategy would take account of the industrial strategy developed in the National Economic Development Council.

7. The Direction required the NEB to prepare and submit to the Secretary of State each year a Corporate Plan setting out the NEB's strategy for the following years.

8. The Secretary of State determined the NEB's financial duties, pursuant to Section 6 IA'75, to be to conduct their activities with the object of securing in 1981 a return on capital employed of 15 to 20%, such capital to exclude the shareholdings in British Leyland Limited and Rolls Royce Limited, loans to companies in which the NEB had no share investment and investments made under Section 3 of the IA'75 (Selective Financial Assistance).

APPENDIX 5

NEB CORPORATE PLAN 1977-81

1. The NEB's Corporate Plan for 1977-81 was submitted to the Secretary of State by its Chairman in December 1977. In effect, therefore, much of the material relating to the first year of the plan was historic; and its forward look really covered the period 1978-81. It was the first Corporate Plan which the Department had received from the NEB to cover activities other than those relating to Rolls-Royce and British Leyland.

2. The plan listed Office Equipment as one of 10 industrial sectors identified as areas of high priority for which detailed strategies were being or had been prepared. The Plan indicated the likely expenditure on each sector over the period of the Plan. However, the office equipment sector was not given a separate and specific allocation in the Plan; £150m was proposed as a sum to cover initiatives in three other sectors as well as office equipment: offshore engineering, power plant manufacture, and telecommunications equipment.

3. The Plan gave the following reasons for having identified the Office Equipment sector as requiring an initiative by the NEB:—

(i) The Office Equipment market was one of the largest and fastest growing sectors of the UK economy.

(ii) UK companies had dropped out of key segments of the market and the UK market was becoming increasingly dominated by extremely large multinationals.

(iii) Few of the remaining UK companies had either the technology or the capacity to exploit the market for "The Integrated Office of the Future".

4. The Plan stated that detailed plans for the Office Equipment Sector were being prepared and that a decision had been taken to concentrate on four distinct market areas one of which was "The Integrated Office of the Future".

5. An initial discussion of the NEB's Corporate Plan took place on 23 January 1978 between the Secretary of State and the Chairman of the NEB with senior officials and NEB staff present. The Secretary of State welcomed the links between the Plan and the Government's industrial strategy. The discussion of particular sectoral aspects of the Plan took place only in the most general terms. All that was said in relation to office equipment was that the NEB were trying to develop something with Muirhead and that they hoped to link it with their computer interest. Some discussion took place about whether the NEB's staff was adequate for the tasks it envisaged and it seemed to be agreed that the staff were stretched but adequate. It was agreed that discussion of the plan would continue in more detail at official level.

6. A series of sectoral discussions took place with the relevant industrial sponsor divisions of the Department and sometimes with Treasury officials in the following months. The meeting on the office systems sector was the last of these and took place on 24 July 1978 – after the NEB Board had considered a strategy paper covering the high and medium technology segments of the Office Equipment market and had sought the Department's consent for the first step in putting its strategy into practice, an investment in Logica.

7. The discussion of an office systems strategy outlined the NEB's intention to establish a company to take over exclusively and substantially expand the sales and marketing operations of the NEB's "building block" companies, and eventually to link the products of these companies into complete systems. NEB staff said that the strategy would involve expenditure of the order of £50m spread over approximately five years. This was to be spent on setting up and financing the company and investing in the "building block" companies, who, according to the record of the meeting, would fund their own R&D and production.

8. At the end of July 1978 the plan was endorsed, in general terms, by the Department. The Secretary of State, in a written Parliamentary answer on 1 August 1978 announced this endorsement and declared that the NEB's approach by means of detailed studies of a number of industrial sectors was of fundamental importance.

APPENDIX 6

DoI APPROVAL OF NEXOS PROPOSAL

1. The NEB wrote to the Department on 5 October 1978 to seek approval, pursuant to Section 10, Industry Act 1975, for the proposed establishment of Nexos. The letter referred to the discussions on 24 July between the NEB and the Department about the office systems strategy (referred to in Appendix 5, paragraph 6). It said that the proposal was that Nexos should begin trading on 1 January 1979 and that the initial commitment from the NEB would be £12m of equity finance, to be called over three years, and £3m of loan finance.

2. The Department's stated practice at that time was to take the NEB's commercial judgement for granted and convey Ministerial approval promptly unless wider policy issues were raised. A degree of special consideration was given to the Nexos proposal because one of the National Economic Development Council Sector Working Parties (SWP) had expressed views on the question of office systems and the Department therefore had to consider the relationship of the NEB's proposal to the Government's industrial strategy.

3. Discussion within the Department established that the NEB's proposal was generally in line with the strategy being formulated by the Office Machinery SWP for the automated office segment; in particular with a recommendation that:—

> the British owned companies making word processing equipment were small companies and that they should be encouraged to get together, possibly with NEB help, to build up an indigenous capability.

4. However, the SWP was reported to be unconvinced from what it had heard that the NEB's research into the best way to proceed and the coverage of the proposed Nexos venture had been adequate.

5. The SWP doubts were exposed to Ministers but the Department took the view that the NEB's commercial judgement should nevertheless be accepted. The Department's approval was given on 14 November 1978, and the approval letter referred to the SWP's views and said that in developing plans for the sector the NEB should maintain the closest contact with the SWP.

APPENDIX 7

'PUT' OPTION OVER SHARES OF LOGICA SECURITIES

1. Mr Moffat has told us that he became aware of the possibility that Logica shareholders had an option to 'put' shares of Logica VTS on NEB at a price of ten times the earnings of Logica VTS but this was never confirmed to him. He was concerned that an option could have provided a motive for Logica to bleed as much money as possible from Nexos into Logica VTS via the S&MA. This appears to be a reference to the option agreement referred to in paragraph 4.41 (g) of this report which related to shares in Logica Securities and was at a price of ten times the consolidated earnings of that company.

Potential Incremental Sale Proceeds from Increasing Profits of Logica VTS

2. The additional potential gain to the Logica management and employee shareholders, as a body, from increasing the pre-tax operating profit of Logica VTS by, say, £100,000 would have been £81,806 calculated as follows:—

Incremental pre-tax operating profit, say	£100,000
Taxation thereon at 52%	£52,000
Incremental post-tax profit	£48,000
Proportion thereof attributable to Logica Securities – 57%	£27,360
Incremental profit per Logica Securities share (100,000 issued shares)	27.36p
Incremental sale proceeds per share under 'put' option—multiple of 10 times	£2.736
Incremental sale proceeds of 29,900 shares in Logica Securities subject to the 'put' option and owned by its management and employee shareholders	£81,806

3. Thus the Logica management and employee shareholders, as a group, stood to gain an additional 82% of the amount by which they could increase the profit of Logica VTS in a financial year *provided* they exercised their option to sell *all* their shares subject to the option to the NEB immediately following that financial year.

Relative Contribution of Logica VTS to Logica Securities as a whole

4. The profit contribution of Logica VTS to Logica Securities as a whole was relatively small. This can be seen from the following figures.

5. The pre-tax profits of the companies were as follows:—

£K		Year ended 30th June 1980	1981
(a)	Logica VTS	189	358
(b)	57% thereof attributable to Logica Securities	108	204
(c)	Logica Securities consolidated	490	2,041
(d)	As a % of Logica Securities ((b) as a % of (c))	22%	10%

6. Having a regard to the above figures I am inclined to the view that any motive to "milk" Nexos would have been weak.

APPENDIX 8

NEB AND DOI ATTITUDE TO IMPORTED PRODUCTS

1. There has been criticism that, given the NEB's reasons for setting-up Nexos, it was allowed to import foreign products. Through UDS it imported and sold Japanese printers and word processors from Ricoh, through MOSL it imported Japanese facsimile machines from OKI and it proposed to import the Delta communications management computer from the United States until such time as it could establish a manufacturing source in the UK. In fairness it should be pointed out that UDS was already importing the Ricoh equipment and its acquisition by Nexos changed nothing.

2. The views of the NEB and the Department on this issue at the time the UDS acquisition and the Delta licence were approved, in so far as they can be ascertained from documentary records, are summarised below. It appears that it was recognised that the Nexos management were proposing to import foreign equipment but, for various reasons, this was accepted by the NEB and the Department.

The NEB Executive Review

3. The NEB's Executive Review (see paragraph 5.20 of this report) of the July 1979 Nexos Corporate Plan recognised that it would result in Nexos importing foreign equipment. The import of a daisy-wheel printer was seen as unavoidable since no UK source existed and it was not felt worthwhile to establish a UK base in the technology as it was felt that daisy-wheel printers would be superceded. The Ricoh word processor was justified as being complementary to existing and planned Nexos word processor products. However, no mention is made as to whether import of the Ricoh word processor would potentially displace UK manufacturers of similar word processors from supplying Nexos. A link with Ricoh was seen as very valuable to Nexos in view of its expertise in copying and as a potential supplier of an electronic typewriter. No specific comment is recorded on the supply of the Japanese OKI facsimile machines but it appears to have been regarded as inevitable as the Japanese were thought to have been two to three years ahead of Muirhead who, nevertheless, were regarded as the only European manufacturer with the right mix of scanning, transmission and receiving technology for Nexos. No alternative was seen to Delta and its import was regarded as a short term measure pending UK manufacture.

NEB Chairman's Advisory Committee

4. The minutes of this Committee, which considered the Corporate Plan before its approval was requested from the NEB Board, contained no reference to the fact that the Plan's main proposals would result in Nexos importing foreign equipment.

NEB Board Meeting

5. The minutes record that Mr Moffat made the points that the Ricoh products would be complementary and that Delta would ultimately be manufactured in the UK and incorporate British software. They do not indicate any discussion or view on the issue.

DoI Approval of UDS Acquisition

6. This was requested by the NEB pursuant to Section 10, Industry Act 1975. The NEB's letter of request stated that the principal activity of UDS was the sale and maintenance under exclusive licence of a word processor manufactured by the Japanese Ricoh Corporation. Apart from the advantages of avoiding having to build up a sales and service organisation from scratch, the letter said that in some cases Ricoh offered cheaper alternative products to those that Nexos was importing from the USA (SIC).

7. In considering the application for consent, the Department noted that UDS imported Japanese equipment and hoped that this could in due course be supplanted by British products. Nevertheless, an unqualified consent was given for the acquisition of UDS by Nexos.

APPENDIX 9

THE NEB REVIEW OF NEXOS

Introduction

1. This appendix contains a summary of the review document considered by the NEB Board in October 1980 and a summary of its consideration by the Board. The review document contained a revised summary corporate plan, dated October 1980, and the results of the review of Nexos.

2. The review was conducted by a team headed by NEB Board member Sir George Macfarlane and consisted also of four persons from Arthur Andersen & Co and two from Patscentre International assisted by four NEB staff, including Mr Dawson. The review is stated to have taken eight weeks.

3. The review culminated in a presentation by the review team to Sir Arthur Knight and NEB executives on the morning of 16 October followed by an abbreviated presentation in the afternoon to those NEB Board members who wished some background detail to the review.

4. The results of the review were contained in a bulky document which was formally presented to the NEB Board at its meeting on 17 October 1980 by Sir George Macfarlane and Mr Dawson. This document comprised the following parts:—

A Revised Summary Corporate Plan dated October 1980
An Assessment of the Plan
Appendices to the Review document:—

(i) A Summary Financial Assessment, by Arthur Andersen & Co;
(ii) A Summary, by Patscentre International, of the conclusions in their separate report on Aspects of Nexos Development Plans;
(iii) A Review of Supplier Relationships, prepared by Mr Dawson;
(iv) Reviews of Logica VTS and MOSL, prepared by Mr Dawson;
(v) The Office Systems Market Opportunity and Competition;
(vi) The Nexos/BT Joint Venture;
(vii) A Summary of Nexos Product Strategy, by Arthur Andersen & Co;
(viii) A Review of Nexos' Market Assessment by Arthur Andersen & Co.

The review document did not contain any recommendations but limited itself to pointing out the key issues and options.

Revised Summary Corporate Plan dated October 1980

5. The first section of the review document comprised a summarised revised corporate plan, dated October 1980, written by Nexos. Its introduction stated that it incorporated amendments to take account of the cash limit of £15.8m that was to apply until the end of December 1980, and the fact that a critical product launch (the 2200) had been delayed. The document was structured to refer to three "cases", which were ways of dividing up Nexos' plans into components based on the level of sophistication of its products. Case 1 incorporated the basic products, ie word processors, facsimile machines and local communications systems; Case 2 included voice and integrated office controllers; and Case 3 took in advanced products still at the conceptual stage. These cases were not alternatives, and for Nexos to develop in accordance with its systems objectives would have required all three cases.

6. The plan began by restating Nexos' objectives in terms of the market it saw itself as addressing, and described its product strategy. It described "Phase 1" of its product strategy as the requirement to establish competitive products in word processing, facsimile and voice. Further phases would result in the development of increasing levels of integration of these basic products. The launch of the 2200 was envisaged in the plan as occurring in October 1980. The 6400 facsimile machine (the OKI 6000) was stated to be available, and a new facsimile machine was to be launched in January 1981. This machine, to be called the 8300, was a digital machine to be supplied by OKI.

7. Discussing the sources of products, the Plan said that experience to date had shown that Logica had significantly overrun on the 2200 programme, and that attention was being given by Nexos to project management of the programme and the build up of Logica's manufacturing capability. As regards facsimile products, the Plan noted that most of Muirhead's products were factored from Japanese sources. The Plan said that their performance on development of the Avon/Tyne system had been excellent, but poor in other areas. Reference was also made to a distributorship agreement with Systime and to the rights Nexos had to the Ricoh printers, and to Delta.

8. The financial forecasts in the Plan showed a turnover in 1980 of £5.6m with a net loss of £8.4m on the basis of case 1 and a net loss of £8.7m on the basis of cases 1, 2 and 3. For 1981 they showed turnover of £26.1m with a net loss of £3.5m on the basis of case 1 and turnover of £26.9 with a net loss of £5.8m on the basis of cases 1, 2 and 3.

9. On the assumption that bank borrowings of £1.52m could be obtained in 1983, they showed theoretical funding requirements from the NEB (including the £15.8m already approved) for :—

Case 1 of	£23.633m in the period to 1982;
Cases 1 and 2 of	£27.819m in the period to 1983;
	£29.618m in the period to 1983;
Cases 1, 2 and 2A of	£35.155m by 1984, being the last year of the
Cases 1, 2, 2A and 3 of	projections.

Review Team Assessment of Nexos Corporate Plan

10. In its assessment the review team noted that Nexos had recruited management with the skills and experience required to run a major company and had commissioned a substantial product development programme. It commented that these were expensive and that sales of £40m-£50m per annum were required to break even.

11. The assessment also stated that the cash required to fund Nexos was very sensitive to the growth in sales that could be achieved. Since the plans for sales growth were ambitious, the review analysis had focused on the evidence available to support their realism.

12. It pointed out that a consequence of the high level of fixed expenditure on central management and product development would be that a less rapid growth in sales would postpone the breakeven date and increase the funding required.

13. The assessment pin-pointed a number of requirements in order to achieve the rapid sales growth planned. These included a rapid market penetration by Nexos. It noted that 45% of the forecast 1981 turnover was planned to be from word processors and that, in order to achieve this, Nexos was forecasting to have about 25% of the UK word processor market by the end of 1981. It stated that this was an ambitious target but noted that Nexos already had one of the largest sales forces (fifty salesmen) in the UK, with about 20% of the word processing salesmen in the UK. As regards facsimile, the plans were less ambitious, with Nexos simply planning to maintain its current market share in the UK.

14. The team felt that the 2200 was likely to be competitive with other products on the market at the planned launch price, and that the other word processor and facsimile products were, or were likely to be, competitive.

15. As regards the supply of products, the team believed there was no reason to doubt the availability of reliable products where these were sourced from abroad. However, the 2200 was being manufactured by an untried production team in new premises. The arms length relationship with Logica, they said, might slow down the process of clearing up any problems which might arise, and there was a risk that during the initial production of the 2200 the quantity and quality required might not be achieved. The other products under development were however felt to be planned to realistic time scales and budgets.

16. The team noted that in Case 1 Nexos was seeking peak funding of £22m to achieve a profit level of £17m. On a valuation of ten times earnings this would give a potential market value of £170m, which, it was pointed out, would provide a substantial return on the NEB's investment and a wide margin for absorbing shocks.

17. In a summary of their assessment, the review team concluded that:—

(*a*) Nexos had set itself ambitious targets for growth in sales volume and there was a significant risk that these targets would not be achieved;

(*b*) there was a risk that the NEB might have to provide further funds;

(*c*) the product strategy and products defined so far were competitive;

(*d*) the planned rate of return to the NEB was high and it would require major shocks before the rate of return was reduced to an unacceptable level;

(*e*) the plan was critically dependent on the success in the UK in 1981 of the about to be launched 2200.

The first and last of these conclusions later proved to be particularly apposite.

Summary Financial Assessment by Arthur Andersen & Co

18. This appendix was written by Arthur Andersen & Co and stated that their work included reviewing the basis for the forecasts in the Nexos Corporate Plan; reviewing the accounting policies used; probing the plausibility of the main assumptions and discussing alternative assumptions; and checking that the forecasts had been properly compiled using the assumptions and policies given.

19. They pointed out that the NEB Board should appreciate that the three cases in the revised plan were inter-related and that as a consequence the total funding requirement for all three cases was likely to be required.

20. The sensitivity analysis carried out and regarded as relevant to the Plan covered the following possibilities:—

(*a*) the impact of slower overall sales growth, ie sales of £115m pa achieved by 1986 rather than 1984;

(*b*) the impact of changes of 10% in salesmen's productivity;

(*c*) the effect of varying assumptions as to the total word processor market;

(*d*) a decrease in margin on the 2200 of £250;

(*e*) an increase in the collection period for debtors;

(*f*) a reduced level of Systime small computer sales;

(*g*) change in the size of the leasing portfolio.

21. The results of the sensitivity analysis confirmed the Conclusion that increased NEB funding could be necessary. The amounts varied, but either of the first two assumptions could have resulted in a further amount in excess of £10m being required by 1984.

22. The assessment went on to point out that the relationship between Nexos and its principal suppliers, Logica VTS and MOSL, was crucial to success and that there was no firm agreement for the transfer price of the 2200.

23. Although the review team were instructed by the NEB to look at the prospects for attracting a private sector partner into the venture, this question seems not to have been addressed. However, the financial assessment did contain a section on the potential for divestment which looked at the value of Nexos were the NEB to discontinue funding. This concluded that it would be extremely difficult to assess a liquidation value for the company since the contractual relationships with the suppliers would be a considerable constraint. But it said that there would certainly be a major write-off of the existing £15.8m investment.

Summary of Conclusions of Patscentre International

24. This appendix consisted of the Conclusion section of a separate report from Patscentre International. This Conclusion section stated that it contained the conclusions from the four previous sections. It appears that Patscentre's review was limited to the Tornado 1, Avon and Tyne, and Delta projects and its conclusions were grouped under these headings.

Tornado 1 Project

25. This was the project involving the linking of 2200 word processors into a network. In general Patscentre were favourably impressed by the Logica proposal for software development.

Avon and Tyne Projects

26. These were the linked projects to develop a decentralised scanner and a store and forward facsimile facility. Patscentre's principal conclusion was that the existing software plan for the store and forward facility was unrealistic because insufficient contingency had been allowed. They recommended that it should be redrawn to cover at least 52 weeks.

Delta

27. They pointed out that whilst the system should be capable of providing the high integrity service required for telephone switching applications this had not yet been demonstrated nor had it been thoroughly investigated by Nexos personnel. They also concluded that it was probable that the hardware would need some modifications and major changes would be needed to the software. They stated that they expected the conversion to cost in excess of £4m and to take more than four years to complete.

General

28. Overall Patscentre concluded that the projected business plan of Nexos was of high risk and required an entrepreneurial style in all activities, including development. They stated that budgeted expenditure on development was too low and mentioned pre-launch testing and product support in the field as specific areas.

Review of Supplier Relationships

29. This appendix reviewed the relationship with Logica VTS, Muirhead and Delphi. It was written by Mr Dawson but incorporated conclusions from Patscentre's review.

Logica VTS

30. It referred to disputes between Logica VTS and Nexos about financial arrangements and said that some related to the start-up phase and some had been exacerbated by the 2200 delay combined with tight cash constraints imposed during the review process. It stated that all disputes appeared capable of resolution. However, it stated that two issues would always be present: financing of development projects and fixing transfer prices. It recommended that Nexos be asked to submit proposals on these issues.

Muirhead

31. It stated that substantial delays had occurred in developing the T30 which had had a significant effect on Nexos' 1980 sales, profits and cash. It also stated that the product was being sold but the delays had shortened an already very limited product life.

32. The scanner development project (Avon) was stated to be well advanced and at least on target on costs and timescale. Patscentre considered that the main project hurdles had been overcome and that plans for the remainder of the project appeared realistic.

33. With regard to the Store and Forward Facsimile project (Tyne) it reported Patscentre's concern that the software development estimates in the business plan did not have an adequate contingency. Generally Patscentre considered that the facsimile developments represented good value for money technically but that this might not be true of future projects.

34. The review referred to financial disputes but said these should reduce once the start-up phase was over.

Delphi

35. The review stated that there was no agreed development plan for Delta although considerable thought had been given to possible options. It reported Patscentre's conclusions that the Delta system would form an excellent basis for an office

communication system which could provide voice, facsimile, and data switching and storeage. Also, that it could be developed as a large PABX but that this was a major project which would require new skills for Nexos.

REVIEWS OF LOGICA VTS AND MOSL

36. These reviews were written by Mr Dawson.

Logica VTS

37. The review covered the five year plans of Logica VTS. It referred to considerable problems in the relationship between Nexos and Logica VTS. It stated that Logica VTS faced a series of immediate and formidable tasks, all of which were in connection with the recent establishment of volume manufacturing facilities at Swindon. It also stated that Logica VTS was facing an extremely tight cash situation and concluded that there was a substantial risk that additional equity financing would be required in 1981/82.

MOSL

38. The review referred to disputes between Nexos and Muirhead and to the possibility of needing to re-inforce the management and technical skills of MOSL.

THE OFFICE SYSTEMS MARKET OPPORTUNITY AND COMPETITION

39. This appendix appears to have been written by Nexos since it is a copy of part of the July 1980 Corporate Plan.

40. It quoted the results of an independent forecast of growth in four sectors of the office equipment market between 1978 and 1983. It concluded that even a small percentage of the forecast market would provide sufficient turnover to support a substantial company.

41. It reviewed Nexos' competitors in the market, both UK and foreign companies. It concluded that the foreign competitors were likely to dominate the market in the long term but that they were constrained at that time by their existing product bases. The exception was Exxon but the Delta licence was stated to have diminished the threat in Europe for 10 years.

42. This led to the conclusion that there was a 5 to 6 year window of opportunity which, if Nexos could take advantage of it, could result in a company which was capable of surviving and growing thereafter.

NEXOS/BT JOINT VENTURE

43. The appendix outlined the proposed joint venture with BT to sell a Telephone Answering Service on a bureau basis using the Delta computer. It gave outline figures but stated that these had not been included in the Corporate Plan.

44. The appendix said that the proposed joint venture was particularly important for Nexos because it would demonstrate the Delta machine in commercial operation, would gain credibility for Nexos, and would build up operational experience by large companies which would help extend the potential market for Delta.

SUMMARY OF NEXOS PRODUCT STRATEGY

45. This appendix to the review document contained a summary of and review by Arthur Andersen & Co of Nexos' product strategy over the following four years. It concluded that Nexos' overall long-term strategy could not be shown to be correct unless evidence could be produced to answer two key questions:-

(*a*) would the very powerful voice handling capabilities of the Delta really be effective in improving the use of managers' time?

(*b*) how would a manager make use of Tornado II facilities (the capability to merge voice, text, image and data into composite "documents") to make himself more productive?

46. It suggested that hard evidence was not yet available and that, in its absence, a decision to back Nexos represented, at least in part, an act of faith. But it pointed out that such a decision would not necessarily be wrong and might prove to be extremely far-sighted.

Review of Nexos Market Assessment by Arthur Andersen & Co

47. The review was based on the July Corporate Plan base case but just prior to its circulation Nexos submitted a revised Corporate Plan. It is not clear what figures in the review relate to the July Plan and what, if any, to the revised plan.

48. The review concentrated more on the rate of growth forecast between 1981 and 1984. In comment on the Nexos sales forecast for 1981 the review stated that Nexos was aiming for between 20% and 30% of the UK market for word processors and noted that Nexos' 50 salesmen constituted about 20% of the total word processing salesmen in the UK.

Review Team Presentation to Sir Arthur Knight on 16 October 1980

49. The presentation appears to have comprised a review of the strategy, products and revised corporate plan of Nexos with views on individual aspects but with no overall recommendation. Mr Dawson then summarised the decisions needed to be made by the NEB. Points that came out in Arthur Andersen & Co's presentation included:-

(*a*) that Nexos had grown its establishment and costs to support sales five times larger;

(*b*) the success of the 2200 (which was then being launched) was critical;

(*c*) there was an urgent need for a business plan for Delta, which was unique but could be too powerful for immediate use.

NEB Board Consideration of Review Document at its meeting on 17 October 1980

50. The Board considered the review document at its meeting on 17 October 1980.

51. Nexos' case was put by Mr Moffat. The minutes record him as saying that he believed the sales target, of 25% market share by the end of 1981, was realistic notwithstanding delays in the launch of the 2200. Nexos was accordingly asking for NEB agreement in principle to increase funding from £15.8m to £35.2m over the whole period of the 1980 Corporate Plan, and specific approval for an increase in funding in 1981 from £15.8m to £27.8m, £3m of which would be subject to specific approval of proposals which would be submitted to the Board. The Nexos plan was ambitious, but even if it were subject to a number of severe shocks it would still provide the NEB with a modest profit.

52. The minutes record that Sir George Macfarlane, as leader of the review team, was invited to sum up its conclusions. However, these are not recorded in the minutes, presumably because they are in the review document. The minutes record Sir George Macfarlane as going on to give his personal views. He said that Nexos was clearly a high risk venture and he could not say with any confidence whether the company would be successful if it were to rely exclusively on its text/image products. The key question was whether Nexos could become a market leader in office systems as a result of its voice products, for which the market was largely unproven. He said that in his view it would be right for the NEB to continue to support Nexos at least until the end of 1981, during which time it should be possible to prove market prospects for the Delta system in the UK and to establish Exxon's intentions for Delta in the United States market. The proposed joint venture with BT would be a very important part of the market assessment provided by this further funding period, since it would make Delta a show piece in the UK and would demonstrate a commitment by a PTT, which would be crucial for the success of the controller concept.

53. In summing up the key issues for the NEB Board, Mr Dawson drew attention to the following:-

(*a*) the plan envisaged total funding of £35.2m but sensitivity analyses suggested that up to £50m might be required;

(*b*) the need for a decision on Nexos funding in 1981–the Plan envisaged £12m, bringing total funding up to £28m;

(*c*) the need for "milestones" in mid-1981 against which to check progress;

(*d*) the need to test Exxon's commitment to developing and promoting the Delta in the US;

(*e*) the need to resolve Nexos' relationships with suppliers;

(*f*) the need to appoint a Chairman for Nexos;

(*g*) the timescale for introduction of private sector finance.

54. The Board then discussed the review after the review team had left. In discussion they noted that Nexos was heavily dependent on outside contractors and there was therefore a substantial risk of production problems. It would be difficult to justify further NEB investment in Nexos as a company specialising in facsimile and word processing products. The case for NEB involvement rested on the premise that Nexos might obtain a substantial share of the market for systems in 3-5 years time, developing market acceptance for its ring main and Delta products on the back of its conventional products.

55. The Board agreed that there were very substantial risks attached to its continuing support for Nexos but in view of the special statutory objectives of the NEB, agreed that funding of £12m in 1981 should be approved and that it should approve in principle the Nexos Corporate Plan for 1980-84 subject to the establishment of appropriate "milestones". The minutes of the meeting go on to state that "the NEB should also seek as a matter of some urgency to test Exxon's attitude to the Delta system; to resolve issues affecting Nexos' relationships with its suppliers; and to appoint a strong non-executive Chairman of Nexos." The Board agreed to consider prospects for introducing private sector finance into the company when it reviewed progress by Nexos in mid-1981.

APPENDIX 10

Nexos Office Systems Limited
Nexos House Whitefriars
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Telephone: 0272 290841
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The Rt Hon Sir Keith Joseph Bt Pc MP
Secretary of State for Industry
House of Commons
London SW1

18 February 1981

Dear Sir Keith

You are currently considering the future of NEXOS. The Executive Directors responsible for running the Company are most anxious that you should be directly aware of their views. In summary these are:

1. That there is both the opportunity and the need for a major U.K. Office Systems company and that NEXOS can fulfil that need. Our strategy has commanded the confidence of a wide range of customers observers and indeed of NEB. We are beginning to demonstrate our ability to achieve the key elements of that strategy.

2. That the need for NEXOS should be treated as a separate issue from the need for NEB.

3. That the present 'drip feed' funding arrangement has taken the company to the brink of collapse, placing at imminent risk the entire investment of over £20M. THe collapse of NEXOS could be seen to result directly in a large financial benefit to certain suppliers, notably Logica VTS Limited, who thus have a vested interest in our demise. This could be seen as an abuse of public funds.

4. That it is wholly desirable, and has been the wish of the Executives from the outset to obtain Private investment as early as possible, but that to achieve this the company requires funding of up to £15M in addition to the amounts currently authorised, with no further demands on Government. Thereafter the responsibility for success would lie entirely with the Directors of the company.

5. That it is a prerequisite to Private investment, confirmed by Michael Richardson of Cazenove, who has agreed to being quoted, that there is a merger of Logica VTS with NEXOS, which can only be achieved by strong resolve on the part of Government and NEB. Without this the Executives could not recommend further funding, given the objective of achieving Private Sector investment.

6. That a major Office Systems venture requires strong management with experience of large volume business and that in the event of a decision to close NEXOS Logica VTS or any of our other suppliers, would be wholly unsuitable bases on which to build such a venture.

These are the essential thoughts which we wish to put before you.

However, there are many other matters concerning the position of NEXOS of which you should be aware. In particular the NEB, perhaps primarily as a result of changing circumstances has been an extremely difficult environment for the company to work in. The new Chief Executive, Brian Willot, is doing everything possible to solve the problems which he inherited and Sir Frederick Wood is I believe sensitive to our difficulties. However, the Executives are anxious that you should be aware of the views in the attached letter to you from our Financial Director, which is written from the standpoint of a professional accountant. His views are endorsed by the other signatories to this letter.

I write to ask you for two things. Firstly for a very urgent decision to provide funding of up to a further £15M on the understanding that we will not seek more.

Secondly for your explicit support in insisting on a merger of Logica VTS and NEXOS as an essential requirement in meeting our mutual objective of taking a successful company to the Private Sector.

Yours sincerely

D M Moffat
Managing Director

J D Wilkinson
Financial Director

P E G Hooton
Marketing Director

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The Rt Hon Sir Keith Joseph Bt Pc MP
Secretary of State for Industry
House of Commons
London

17 February 1981

Dear Sir Keith

It is with great reluctance that I find it necessary to write to you in your capacity as the representative of the ultimate shareholders of this company to express my personal concern as to the manner in which this company has been required to operate. I am assuming that by writing to you I am not acting in contravention of my service agreement with Nexos and that you are entitled to all information concerning the NEXOS venture. I am not writing to you in any other context than between a director and a shareholder.

By way of background I should explain that all four of the executive directors of Nexos were recruited from senior positions in high technology multi-national companies to put into effect a NEB concept to create a major British company in the integrated office equipment business. It was and still is the opinion of the executive directors that such a company could be created and that the opportunity to successfully attack the current American hold on the existing marketplace still exists. In the event, Nexos was burdened from the outset by Supply and Marketing Agreements with two British high technology companies, Muirhead and Logica, which were so poorly drafted as to result in a continuous flow of very large sums of money to those companies with little or no regard to any considerations of value for money or performance on the part of the supplier. To illustrate the inadequacies of these agreements I have attached Counsel's opinion on the Logica Agreement. Despite all of our efforts to obtain assistance from NEB to address the inequities of these agreements, and the Logica Agreement in particular, and the resultant possible misuse of public money we are now faced with a NEB chosen course of action that will undoubtedly result in further funds passing to Logica. As an individual I do not feel that I can be a party to such perpetuation of improper use of taxpayers' funds and have written to my managing director and via him to NEB, expressing this opinion.

The original concept of Nexos and the nature of the Supply and Marketing Agreements with the key suppliers required very strong executive involvement by NEB staff in the operations of the various companies involved. The executive directors did not have this direct executive capability within the key suppliers although the key suppliers had board representation in Nexos. For many reasons, mostly due to force of circumstances, the NEB did not carry out their essential role in the Nexos venture and the significant and costly problems to do with supplier relationships has arisen primarily from these key deficiencies in the implementation of the original concept.

It has been apparent for over a year that the possibility existed that it may have been the intention of Logica to take every possible advantage from the Supply and Marketing Agreement and to emerge from their involvement with Nexos as the only vehicle by which NEB may salvage part of their expenditure on the Nexos project. In the event that Nexos founders through uncertainty then Logica could present a proposal to NEB that Logica VTS Limited, in which NEB has a 43% shareholding, should own all rights attaching to the results of development work paid for by Nexos.

The amount so far paid by Nexos to Logica through the auspices of agreements inspired by NEB and entered into with that company amounts to in excess of £5 million which does not represent the total cost of our relationship with Logica as the high cost of putting into place a marketing operation based on unachieved delivery forecasts should also be taken into account.

As an example of our difficulties I would mention that over the latter part of 1980 an amount in excess of £700,000 had been demanded from Nexos by Logica and notwithstanding our strenuous efforts to obtain assistance from NEB in dealing with this matter we received no support in contesting the claim. Eventually in desperation we obtained Counsel's opinion which concluded "in the circumstances it would be wholly improper for the directors of Nexos to pay the amount claimed."

During my involvement with NEB since July 1979 I have been directly aware of certain transactions which as a chartered accountant who takes his profession seriously, I consider to be an abuse or misuse of authority. In particular I would refer to the following:–

(a) In September 1980 Nexos was actively encouraged by a staff member of the NEB to order equipment from Systime Limited for delivery in 1981. During the course of discussions on this subject it became apparent that the primary motivation was the achievement of required profit and turnover figures by Systime to do with a transaction in shares. Having become aware of this situation I stated that I would have no part of such a transaction and this attitude was endorsed by the other executive directors. Systime then proposed that we purchase the rights to a product developed by them for an amount of £120,000. On the express understanding that no part of this consideration would be reflected in Systime's financial accounts for the year ended 30th September 1980 we agreed to this transaction after having included a clause in the agreement, dated 3rd October 1980, that would result in a similar amount being paid to Nexos by way of liquidated damages in the event that the product was not delivered in a marketable state by a specified date. In late 1980 Nexos received a request from Systime's auditors for confirmation that on 30th September 1980 Nexos owed Systime the amount of £138,000 (£120,000 plus VAT). I responded to the auditors that there was no indebtedness to Systime at 30th September 1980 and informed the NEB appointed director of Systime that it was apparent from such request for confirmation that Systime had taken this amount into its accounts for the year ended 30th September 1980 and that I considered this to be improper practice. Neither my reply to the auditors or my statements to the NEB director of Systime provoked any response.

In the event the product concerned was not delivered in a marketable state on the due date and we have formally claimed payment of the amount due under the contract, although no payment has yet been forthcoming.

* In the original letter there was no paragraph labelled (b)

(c) During 1980 it became clear that contractual commitments on the part of Muirhead were not being met. In the opinion of the executive directors this failure entitled Nexos to claim a significant reduction in the amounts to be paid to Muirhead in respect of products being imported from Japan and sold to Nexos at an inflated price. Although several efforts were made to obtain NEB involvement in this matter through the relevant appointed directors of the two companies, no assistance was forthcoming.

In discussion with the NEB appointee to the Nexos board it was clear that he was more concerned with the possible effects of the pursuit of the proposed claim which greatly exceeded the then last reported half year profits of Muirhead, on the Muirhead group rather than with Nexos' rights in the matter. Whilst fully appreciating Muirhead's problems at that time and having no wish to irrepairably damage a long established British company of deserved repute, the executive directors were very concerned that the directors of Nexos were required to act in a manner inconsistent with their obligations as directors.

As no retrospective adjustment could be obtained without the support of NEB the executive directors eventually resolved the Muirhead situation in the only way available to them which was by way of a significant reduction in future prices to be paid.

In December 1980 the executive directors were informed by NEB that you had stated that every effort was to be made to attract private sector investment into the Nexos venture at the earliest possible opportunity. Having some experience in this area I explained to NEB and to the board of directors of this company that to meet this requirement it was

imperative to obtain control over the development and manufacturing functions presently controlled by Logica.

The NEB apparently does not agree that this is an essential step notwithstanding that our view has been categorically endorsed by Michael Richardson of Cazenove. Unless this constraint is removed, we would find it extremely difficult to put forward a proposal that we believe meets your requirements to attract private sector investment.

Whilst writing I will take the opportunity to refer to the very significant damage that has been done to the company, and thereby the taxpayer's investment, by the lack of certainty of continued support for the Nexos venture. As was stated very clearly by the independent review team at the time of the October review of our business plan, ventures such as Nexos can only succeed if the degree of commitment by the investor matches the timescale required to reach operating maturity. The possible negative situations that were thought by all of the directors to be likely to arise in the absence of a public statement of unequivocal commitment by the investor have in fact occurred and the company is now in a very serious situation. As the NEB has presumably advised the Department of Industry, Nexos has felt itself to be totally unable to recruit staff whilst the commitment to the required level of funding was absent. This of course leads to an unnatural state of affairs and employees rapidly become concerned for their future and seek alternative employment. The level of the lack of credibility as to our future that is now being actively exploited by our competitors in the marketplace is best demonstrated by a requirement on the part of both the Halifax Building Society and by the Post Office for a statement of continued support by NEB before those entities would consider placing purchase orders with Nexos. If unltimately obtained, the Halifax business will have been won in the face of competition from IBM, Wang, Philips and the rest of the major wordprocessing companies.

This rapidly deteriorating situation will undoubtedly work to the advantage of Logica who have only to wait for the inevitable result of a complete lack of public or internal confidence to become the major beneficiaries of the legacy created by the Supply and Marketing Agreements entered into without ensuring that such agreements provided due protection of the taxpayer's interests.

Yours sincerely,

J D Wilkinson F.C.A.

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PS/*Secretary of State for Industry*

26 February 1981

DM Moffat Esq
Managing Director
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Dear Mr Moffat

The Secretary of State has asked me to thank you for your letter of 18 February. The points which you raise are matters for the NEB and, as you may be aware, were the subject of a meeting which the Chairman of the NEB had with Mr Tebbit and Mr Baker on 19 February 1981.

Yours sincerely

CATHERINE BELL
Private Secretary

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26 February 1981

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The Secretary of State has asked me to thank you for your letter of 17 February. The points which you raise are matters for the NEB and, as you may be aware, were the subject of a meeting which the Chairman of the NEB had with Mr Tebbit and Mr Baker on 19 February 1981.

Yours sincerely

CATHERINE BELL
Private Secretary

APPENDIX 11

TERMINATION OF DELTA LICENCE

1 When the NEB Board agreed on 18 September 1981 to begin to run down the business of Nexos it was decided that efforts should be made to dispose of the Delta licence. By that stage it was clear that Gestetner, whom NEB regarded as the most likely purchaser of the rump of the business, would not be interested in Delta.

2 At first it was hoped that it might be possible to sell the licence back to Delphi for a significant sum. Records at the NEB, including a record of a meeting on 23 September at which Messrs Moffat, Harris, Frost and Willott were present, indicate that Mr Moffat believed that it would be possible to "embarrass" money out of Delphi (because of the delays in the Delta hardware programme). Delphi were being encouraged to believe that they might be able to reposess the Delta licence: it was felt they might want to do this because there had been suggestions earlier in the year that Exxon had ambitious plans for office automation in Europe and had felt that Nexos had done particularly well in getting the Delta licence as cheaply as it did.

3 At the meeting of the NEB Board on 21 October 1981 Mr Willott is recorded as reporting that an approach had been made to Exxon offering to sell them back the Delta licence but they were having difficulties with their office systems business and had not reacted with enthusiasm. Exxon would however be putting together a business plan. It was also reported that discussions with BT and Cable and Wireless on the proposed TAS bureau joint venture between Nexos and BT might lead to a business deal but that it would be difficult to settle anything in the time available.

4 On 2 November the NEB received advice, through its own solicitors, from Californian lawyers on the possible liabilities under the Delphi licence agreement in the event that it was terminated through Nexos' receivership. The advice was that Delphi could be entitled to damages approximating to the remaining minimum royalties payable over the duration of the agreement plus any monies owing on outstanding contracts for the purchase of Delta II systems. In addition it was possible (though admitted to be an open question) that Delphi could sue for recovery of the £1m investment which Nexos was to have made in the devleopment of specific applications for Delta II.

5 On 3 November Mr Harris attended a meeting at the NEB at which the state of play was discussed with Arthur Andersen & Co, who were standing by to be appointed as receivers of Nexos on behalf of the NEB (as explained in Appendix 13). In respect of Delta, Mr Harris is recorded as saying that he had been told by Exxon that there were no Exxon funds available for use in Europe and that they were not interested in the European side of the Delta project. Mr Willott asked Mr Harris to progress the matter with Exxon as far as possible within the next few days. But given that any claim against Nexos by Exxon would be crystallised by the appointment of a receiver, Mr Willott said that if a deal could be arrived at by the Monday (9 November) whereby Nexos got out of its obligations on a no cost basis, it should be accepted.

6 This instruction was ratified by the Nexos Board meeting on 4 November where it was agreed that Mr Frost should fly to the USA immediately to negotiate the best possible terms for termination of the licence. On 6 November an agreement was signed to terminate the licence at no further net cost to Nexos.

7 Perhaps it is of note that in August 1982 it was announced in the press that Exxon had decided to close down Delphi and all 400 staff were laid off.

REDUNDANCY OF DELTA PROJECT STAFF

8 At the time the Delphi licence agreement was terminated Nexos had some 20 staff working on the Delta system in the USA. These staff had re-located in the USA with their dependents and therefore the total number of people affected by the termination was closer

to 60. These staff were made redundant. Mr Moffat told us that much bitterness was created by the way in which their employment was terminated under instructions from the NEB.

9 Nexos' practice appears to have been to give its staff employment contracts based on one month's notice initially, moving to three month's notice after a satisfactory probationary period. Many of the Delta team staff were therefore entitled to no more than one month's salary on termination. The NEB initially took the view that its responsibility for public funds precluded it from allowing Nexos to terminate the employment of its staff on terms more generous than those to which they were contractually entitled. The NEB did, however, agree to allow Nexos to offer an ex gratia payment of a further month's salary to its US-based employees in recognition of the fact that they had relocated themselves in the USA.

APPENDIX 12

SALE OF NEXOS FACSIMILE BUSINESS AND STOCKS

1. In view of comment regarding the disposal of Nexos' facsimile business/assets, and in particular the disposal of stocks of facsimile machines, I set out in this appendix the details of the agreement reached with Muirhead and the background to it.

2. When the NEB Board decided on 18 September 1981 to run down the business of Nexos it was clear by that stage that Gestetner, whom NEB regarded as the most likely purchaser of the rump of the business, would not be interested in the fascimile side. Therefore the NEB Board decided to initiate discussions with Muirhead about the possibility of it taking over Nexos' facsimile business. The NEB used as a peg for an approach to Muirhead a letter that had been written by its Chairman and Managing Director to Sir Frederick Wood in June 1981 which had complained of the way in which Nexos had reduced orders for facsimile equipment and which put the loss to Muirhead arising from its involvement in Nexos at £1.1m. Muirhead had suggested options for changing the situation, and the idea of a sale back to Muirhead of the Nexos facsimile business was an extension of one of these options.

3. Negotiations were opened by a letter from Mr Willott to the Chairman of Muirhead on 18 September, which was a prelude to a meeting that Sir Frederick Wood and Mr Willott had with him on 21 September. The initial letter, drafted on the advice of N M Rothschild & Sons Ltd, did not make a specific proposal in terms of price as it was felt that it would not be possible to make a specific pre-emptive offer. This was because legal advice was not yet available on the liabilities that might be incurred by Nexos for terminating the S&MA.

4. After a discussion at the meeting it was agreed that Muirhead would make a proposal. On 19 October Muirhead made a written proposal, the basis of which was as follows:-

(a) That NEB/Nexos should pay Muirhead £700,000 as compensation for termination of the S&MA to allow Muirhead to re-establish a marketing operation and continue some development begun by Nexos;

(b) that Nexos should honour its current order commitments to Oki;

(c) Muirhead would repurchase from Nexos its stock of Oki facsimile machines at £350 each;

(d) Muirhead was not prepared to repurchase other machines (ie its own manufacture) except at nominal value (with net profit thereafter split with Nexos);

(e) Muirhead would consider re-employment of Nexos' facsimile sales staff;

(f) Muirhead would take on Nexos' lease and service commitments, provided these were not commercially onerous.

5. In order to understand this proposal and how it relates to the subsequent one and to the final settlement, it is necessary to appreciate Nexos' facsimile stock and order position. When negotiations opened the latest known position on total facsimile inventory, at the beginning of August 1981, was:-

	Units	Book Value (written down) £K
6400 (Oki)	535	1,047
6200	209	572
Other	84	67
	828	1,686

6. However, only 746 of these units were directly available for sale, the remainder being on loan, used for demonstration, etc.

7. In addition, a large number of machines were on order from Oki and still to be delivered. At the beginning of August 1981, Nexos was committed to taking delivery of a further 590 machines from Oki *plus* 300 of a new Group III machine that it had been intended would sell as the Nexos 6800. Thus inventory plus the total commitment up to March 1982 was some 1700 machines. The mean monthly sales during 1981 had been 23 machines a month.

8. The NEB rejected Muirhead's proposal saying that it would not be prepared to contemplate a deal significantly more generous than might be expected from a receivership. On 2 November the NEB put forward a counter-proposal, backed by legal advice and Counsel's Opinion. The NEB claimed this showed that Muirhead was unlikely to succeed in a claim for damages for termination of the S&MA and that accordingly the demand on Muirhead's part for £700,000 compensation was unwarranted.

9. The proposal put forward by the NEB was as follows:-

(a) Nexos would pay Muirhead £100,000 to terminate development work, plus £100,000 as a contribution to marketing set-up costs;

(b) Muirhead would repurchase 6400/6401 machines (Oki) at £450 each and 6200 machines (T30) at £300 each; and give Nexos one third of the difference between this repurchase price and any selling price obtained by Muirhead;

(c) Nexos would honour its commitment to purchase Oki machines to total quantity 590, including those already delivered in the course of the negotiations, but with no commitment on the last 300 ordered by Nexos.

(d) Muirhead would consider taking on the Nexos facsimile sales staff.

10. This proposal was not accepted by Muirhead, who stated that it had an alternative legal opinion which suggested that it could claim damages for breach of Nexos' obligations under the S&MA. Negotiations continued and at one stage Muirhead sought to persuade the Department to intervene with the NEB on its behalf. The Department, however, maintained a line that it was a commercial matter for the NEB and Muirhead to resolve in the normal way.

11. Towards the end of November 1981 Mr Willott asked Mr Frost to conduct the negotiations and he reached an outline agreement with Muirhead in the first week of December. Heads of Agreement were signed in the first week of January 1982 and the final agreement signed on 15 February 1982. In summary, this agreement provided that:-

(a) Muirhead would transfer into MOSL the facsimile service activity of MDCL plus tangible assets of some £450,000;

(b) NEB would continue to hold 25% of MOSL; and MOSL would declare all net profits as dividend;

(c) MOSL would acquire for £1 Nexos' facsimile stocks;

(d) NEB/Nexos would pay the landed price of the remainder of the Oki machines still in transit - estimated to be some £245,000; and these machines would be acquired by MOSL for £1;

(e) NEB/Nexos would not be liable for the extra 300 Group III machines but would be liable for half of any cancellation charge negotiated with Oki by Muirhead;

(f) NEB/Nexos to contribute £100,000 to MOSL to assist with re-establishing marketing;

(g) MOSL to offer re-employment to Nexos facsmile sales staff.

12. Thus, in substance, and leaving aside the taxation implications of the agreement, MDCL transferred its facsimile service business plus £450,000 of assets to MOSL and Nexos transferred its facsimile machine sales business plus its unsold facsimile machine stocks and £100,000 of other assets to MOSL; MDCL ran the combined business which was owned as to 75% by Muirhead and 25% by the NEB; and all profits were paid out as dividends to the two owners.

13. Mr Willott explained to us that the rationale for this agreement was that the NEB would benefit to the extent of 25% from any profits made by MOSL from the sale of the facsimile stocks and from the englarged MOSL business.

14. It is also relevant that in October 1984, the NEB disposed of its 25% stake in MOSL to Muirhead for £320,000 by which date it had received dividends from MOSL of £163,000.

15. Whilst the negotiations with Muirhead had been going on Nexos continued with its facsimile business, selling small quantities but taking delivery of machines previously ordered. I have not ascertained the quantity of machines included in the final agreement but Nexos records show that at the end of October its facsimile machine stocks were:—

	Number of Units	Original Cost £K	Book Value (written down) £K
6400 (Oki)	343	725	725
6401 (Oki)	261	405	402
6200 (Muirhead T30)	192	519	519
Other	82	171	66
	878	1,820	1,712

16. Some criticism has been levelled at the NEB for an element of this settlement with Muirhead, namely the sale of the existing facsmile stocks for £1, and those in transit for a further £1. I believe it is misleading to consider just two elements of the agreement with Muirhead in isolation: the proper question to ask is how the agreement as a whole compared with other courses of action then open to the NEB. For example, the NEB could, on the face of it, have sold the bulk of the facsimile machines back to Muirhead for £350 each under the proposal of 19 October. But only at the cost of paying Muirhead £700,000 in compensation for the termination of the S&MA. In theory the facsimile machine stock could have been offered to other parties for onward re-sale to end users. However, it seems likely that before buying a machine a potential end-user would have needed to be satisfied that they could obtain spare parts and a competent service facility. Since the machines were of either Muirhead or Oki manufacture and Muirhead held an exclusive European distributorship for Oki I question whether any party other than Muirhead could have offered such a spare parts and service facility. It seems that Muirhead was in a strong position and would have had to be party to any agreement by Nexos for the sale of its facsimile machine stocks.

17. Mr Willott explained to us that the NEB's principal objective for the facsimile business had been to ensure that there was an on-going business and that Muirhead were really the only party able to take over the running of the business.

APPENDIX 13

SALE OF NEXOS WORD PROCESSING BUSINESS AND STOCKS

1. In view of comment regarding the disposal of Nexos' 2200 word processor business, and in particular the earlier announcement of agreement having been reached with Gestetner, I set out in this appendix a summary of the agreement which effectively disposed of Nexos' 2200 word processor business, together with the background to this agreement.

2. The negotiations that led to the sale of Nexos' 2200 word processing business grew out of the discussions begun at the end of 1980 to try to find a private sector partner for Nexos. When the NEB reported to the Department on the progress of these discussions at the end of January 1981 Gestetner were said to be very keen to do a deal in relation to Nexos, but it was said to have proved exceedingly hard to find out what Gestetner wanted. ICL were also said to be quite enthusiastic about the scope for bringing together Nexos' marketing operations, ICL's manufacturing capability and Nexos' product range. However, in the light of their own difficulties at that time, ICL had deferred discussions with the NEB.

3. During the summer of 1981 an NEB executive developed the "Newco" concept as a possible means of dealing with Nexos and a number of other companies in the NEB's portfolio by their incorporation in a conglomerate of information technology companies. Gestetner also showed interest in this idea.

4. However, by the middle of September 1981 the possible "Newco" had become much more limited, and when the NEB Board met to consider the situation on 18 September, the companies that might be included in "Newco" had been reduced to Nexos, Logica VTS and Systems Programming Holdings Ltd ("SPH") (a software company) . It was reported to the Board that Gestetner was interested in all aspects of Nexos apart from its existing facsimile business. However, at that stage Gestetner was refusing to be drawn beyond a verbal expression of interest, although the fact that it had appointed a merchant bank to advise it on the matter was taken as a clear indication that its interest was serious. The NEB Board agreed that Gestetner and its advisers should be pressed to reach an early decision on whether it wished to invest in Nexos and in the meantime an immediate run-down of Nexos should be instituted while trying to avoid action which would prejudice a deal with Gestetner. Discussions which had been initiated with Logica Securities were to be pursued in parallel.

5. By the time the NEB Board considered the matter further the following month, on 21 October, the Board were faced with a choice essentially between agreeing to a prospective deal with Gestetner or closing Nexos' business. Although Gestetner had still not made a firm offer, the proposal being worked on was that it should take-over the Nexos and Logica VTS 2200 word processor operations and invest further capital to allow production at a rate of 750 machines per month. This would require an estimated £10-12m of which Gestetner was prepared to invest £3m, leaving the NEB (or the Department) to make up the balance.

6. In the discussion at the NEB Board, it emerged that if Nexos were to go into immediate receivership the rights in the 2200 would probably revert to Logica VTS and therefore any deal with Gestetner would have to rely on first obtaining Logica VTS from Logica . The Board concluded that in view of Gestetner's willingness to invest its own funds and its reputation as a major international marketing force in the office equipment business, the prospective deal with Gestetner was the NEB's first choice. Discussions with Gestetner should therefore continue but unless a letter of intent was received by the end of October steps should be put in hand to place Nexos in receivership.

7. During the next two weeks discussions continued with Gestetner, and with Logica. Logica's position appears to have been that Logica Securities would dispose of its controlling shareholding in Logica VTS to the NEB but only in exchange for the NEB's shareholding in Logica Holdings. The NEB regarded this as an unacceptably high price. A further complication developed in that ICL expressed renewed interest in the 2200 and in placing an order for large quantities of the machine.

8. At this stage there appears to have been some confusion as to the extent of ICL's interest in the 2200 word processor. IT Division records the managing director of ICL as having told them on 23 October that he had reached agreement in principle for ICL to take large quantities of the 2200 if Logica VTS recovered the marketing rights. On the other hand Mr Willott had a telephone conversation with Gestetner on 29 October in which it was said that Gestetner understood ICL's only interest in Logica was to get closer to Gestetner, and that the 2200 was not such a good machine. On 30 October, Mr Willott's record of a further conversation with the managing director of ICL suggests that ICL would want to "proceed" in some way with the Logica product but that it would want some technical modifications that would take until the following spring to implement. In view of what happened subsequently, it is relevant to note what was understood by the NEB at the end of October about the interest of ICL in Logica VTS.

9. By the week beginning 2 November no letter of intent had been signed by Gestetner and thus the NEB was on the brink of placing Nexos in receivership. The position was reported to the Nexos Board on Wednesday, 4 November by Mr Harris, who is recorded as reporting that the NEB had still not been able to conclude an agreement with Gestetner concerning Nexos' future, nor had the NEB concluded an agreement for the acquisition of Logica VTS which was a prerequisite of any agreement with Gestetner. The Nexos Board accordingly resolved that unless by close of business on Friday, 6 November terms for a merger with Gestetner and/or Logica VTS were agreed, the Board recommended the NEB to appoint a receiver from Monday, 9 November.

10. Mr Willott told us that the threat of receivership was instrumental in getting Gestetner to reach agreement. Over the weekend of 7/8 November Gestetner agreed in principle to acquire Logica VTS and the word processor activities of Nexos. The NEB understood that Logica Securities was prepared to sell its shareholding in Logica VTS although terms had not been settled by the NEB. Accordingly receivership did not take place on 9 November, and the agreement in principle with Gestetner was announced.

11. Negotiations continued, with the NEB consulting N M Rothschild & Sons Ltd and Arthur Andersen & Co on tactics, and the proposed terms of the deal with Gestetner were considered by the NEB Board on 20 November. A number of issues remained outstanding but the main terms were settled and the Board were able to consider a comparison of the proposed deal with the cost of receivership, this comparison having been agreed with Arthur Andersen and Rothschilds. The cost of receivership to the NEB was put at £6.1m, while the Gestetner deal would cost between £12.3m and £13.7m depending on the outcome of negotiations on the remaining items. The paper to the Board pointed out that there were still major difficulties to be overcome: first, a condition of the deal was that 25% of SPH was to be transferred to "Newco" and the NEB had been unable to persuade the other shareholder in SPH to waive pre-emption rights; second, it was expected to prove difficult to reach agreement with Logica over the transfer to "Newco" of Logica VTS, which was also a condition of the deal.

12. In discussion, the Board noted that receivership was likely to be a considerably cheaper option than a deal with Gestetner but were clear that, having regard to the NEB's statutory functions and purposes as well as to the commercial merits of the deal, a deal with Gestetner was preferable to receivership. They did not believe the prospects for Logica VTS succeeding on its own in the long term seemed good and noted that Gestetner proposed to introduce strong US management into "Newco" to reduce costs and scale up production to enable the 2200 to be sold profitably for under £2,000. They therefore approved in principle the agreement with Gestetner outlined to them and authorised the NEB Chairman and Chief Executive to pursue negotiations with Logica and SPH to bring those companies into the agreement.

13. The Department had been kept in touch with the progress of negotiations and, immediately after the NEB Board had approved the agreement in principle with Gestetner, the Secretary of State's consent was sought for the establishment of "Newco" and the disposal of NEB shares. It was made clear to the Department that the agreement with Gestetner was subject to contract and to the conclusion of negotiations with other parties including Logica. The Secretary of State's consent was given on 25 November 1981.

14. Heads of Agreement between the NEB and Gestetner were signed on 30 November. ICL were still interested in aspects of the business and discussions proceeded between them and Gestetner to try to reach agreement. The position at the end of November appears to have been that both sides agreed that ICL should have a licence to use the 2200, but the main area of difference between them concerned access to the Logica VTS staff working on the Polynet local area network and other developments.

15. On 22 December ICL contacted the NEB with a completely new idea under which they would themselves acquire certain word processing assets. The essence of the proposal was that ICL would acquire from Nexos the right to market the 2200, as well as the word processor inventory. The proposal had the attraction that the NEB would not be required to put new money into the business, as would be necessary under the Gestetner deal, and that ICL were prepared to pay for the word processor inventory acquired. Furthermore, it emerged that Logica were happy with the proposal. An NEB assessment communicated to the Department on 23 December put the ICL proposal at some £9m to the NEB's advantage compared with the Gestetner deal.

16. The NEB could not proceed with the Gestetner deal unless Logica Securities effected the sale to the NEB of its majority shareholding in Logica VTS. Mr Willott told us that although the NEB felt morally committed to Gestetner, Mr Hughes made it clear that he would not now agree to the Gestetner deal. Accordingly the NEB and ICL signed Heads of Agreement on 11 January 1982. The contracts between the NEB, Nexos, ICL and Logica were signed on 12 March 1982. In summary they provided that:-

- ICL would buy Nexos' stocks of 2200 word processors, Ricoh printers and various parts and supplies at book value;
- ICL assumed certain agreements, including those for supplying OEM manufacturers with Ricoh printers;
- ICL would carry on the servicing of 2200s and Ricoh printers and would provide information on upgrades to Nexos GmbH and Nexos Office Systems (Ireland) Ltd;
- Nexos and Logica VTS mutually waived claims against each other, and the S&MA ceased;
- NEB sold its shareholdings in Logica VTS and Logica Holdings for £500,000 and £1.7m respectively to Logica Securities or its nominees;
- NEB sold its shareholding in Logica Securities for £1.245m to nominees of Logica Securities;
- Logica Holdings repaid to NEB a loan of £100,000.

Note by the Department of Trade and Industry (PAC 177)

MONITORING OF THE BRITISH TECHNOLOGY GROUP

1. This note describes the framework for monitoring agreed between the Department of Trade and Industry, the British Technology Group and the Treasury. It follows the government's acceptance of the recommendation by the Committee of Public Accounts that the revised arrangements should combine the best of those previously applied to the National Enterprise Board and National Research Development Corporation. The new system is based primarily upon the information prepared by the British Technology Group itself for its internal managements purposes.

2. Every **year** the BTG prepares, and submits to the Secretary of State for Trade and Industry for approval, a Corporate Plan which provides detailed financial forecasts, together with an accompanying narrative, for the BTG's activities over the next five year period. The forecasts are broken down between the NEB and NRDC sides of the BTG's activities, and can therefore be compared directly with Annual Reports and Accounts. The Plan, as approved, is the benchmark against which the BTG's performance is measured during the year and to which all other management information relates.

3. Every **month** the DTI receives copies of all the papers submitted to the monthly meeting of the BTG Council, and copies of the Council minutes. These documents are described in more detail below. Copies are sent to Treasury and selected papers for the Council meetings are sent to interested divisions within DTI or, in appropriate cases, to other government departments (for example to the DHSS where they deal with exploitation of innovation of special importance to medicine).

4. Every **quarter** there is a monitoring meeting at which the BTG, the Treasury and the DTI discuss progress and prospects against the Corporate Plan and any other matters of mutual interest concerning the BTG's affairs. The basis for this meeting is the latest set of monthly monitoring papers, which is supplemented by a memorandum by the BTG drawing attention to the main events that have taken place during the previous quarter. The meetings normally take place in February, May, August and November. It is of course open to either the DTI or the Treasury to raise matters with the BTG between the quarterly meetings if, for example, they think it appropriate in the light of information provided by one of the monthly papers.

5. The papers for the monthly Council meetings which provide the basis for monitoring are as follows:

(i) **Performance reports** Each of the BTG's three divisions which are responsible for investments prepares a monthly report to the Council on the performance of the investments and projects for which it is responsible, including progress on disposals. These reports deal individually with all the major BTG investments. Monthly reports are not required for smaller investments, but each is considered by the Council at least twice a year.

(ii) **Management accounts** Full management accounts, detailing progress to date against the annual Corporate Plan, and covering both technology transfer activities and disposals, are prepared quarterly. The quarterly monitoring meetings with DTI and Treasury are timed to take place as soon as possible after the submission of these full accounts to the Council. In addition, shorter forms of the accounts are prepared for the Council (and copied to the DTI) on a monthly basis.

(iii) **Operational statistics** These are a recent innovation, and are intended to supplement the management accounts and performance reports with detailed information on the progress of the BTG's technology transfer activities: for example, the number of enquiries received, the number of applications for investments dealt with, the backlog of undecided cases, the number of new licences taken out and old licences terminated the number of staff in post, etc. These too are produced monthly.

6. The BTG's delegated powers to make or dispose of investments are set out in Directions and Statutory Instruments under the Industry Act 1975 (for the NEB) and the Development of Inventions Act (for the NRDC). The present Directions and Statutory Instruments are being revised. Meanwhile the following provisional limits, which have been agreed between the BTG and the Department, are in effect:

(i) for development projects not involving equity investment, the BTG has delegated powers up to but not exceeding £500,000.

(ii) for equity investments, the BTG has delegated powers up to £100,000 provided this does not involve acquisition of more than 25% of the equity share capital of the company in question.

(iii) the BTG has delegated authority for the disposal of voting shares or voting stocks where the book value of the holding amounts to less than £1 million.

(iv) the BTG has delegated powers to incur commitments up to £2 million where this commitment is given to a company in which the BTG holds shares, provided:

(*a*) that the commitment is for the purpose of carrying out the BTG's duty to dispose of its old NEB investments, and

(*b*) the total of such commitments is agreed with the DTI and Treasury on a quarterly basis.

The BTG is also under an obligation to seek the Department's approval for changes in its holding in certain major investments inherited from the NEB.

Examination of witnesses

SIR BRIAN HAYES, KCB, Permanent Secretary, MR COLIN BAKER, Chairman, British Technology Group, and MR RUSSELL FORD, Deputy Director, Industrial Development Unit, Department of Trade and Industry, called in and examined.

MR C H A JUDD, Treasury Officer of Accounts, called in and examined.

Chairman

2936. Welcome to the Committee. Today we are looking at the report of the investigation by the accountant appointed by the Department into the loss of £31 million on the National Enterprise Board's investment in NEXOS. The investigation was undertaken at the request of the Committee. We note from the report conclusions that the prime reasons for the NEXOS failure are rather different from those you gave to the Committee in 1983. Could you give us the explanation for this?

*(*Sir *Brian Hayes.)* It is perfectly true that now that we have the results of this very detailed investigation by Mr Ford, I recognise that in my own earlier evidence I attached too much importance to the unsatisfactory nature of the supply and marketing agreement between NEXOS and Logica VTS. I was in good company in doing so: Mr Oppenheim in an article in "What to Buy for Business" reached the same conclusions after what appeared to be a careful study of the facts and I believe that was also the burden of the Money Programme upon which you appeared, Chairman. I hope the Committee will agree that it is understandable in the then state of our knowledge of the NEXOS story, why I should have done so. As Mr Ford's report makes clear, the NEXOS strategy depended very heavily on the Logica VTS 2200 wordprocessor coming forward at the time NEXOS expected and being highly successful immediately in the competitive market. It did not come forward until later and its sales did not reach the level predicted. That clearly was important and one asked oneself to what extent it was a function of the agreement between the companies. Secondly, there were undoubtedly difficulties in the relationship between the NEXOS management and that of Logica VTS. To what extent they were attributable to personalities, and to what extent they reflected flaws in the agreement itself must be a matter of speculation. Thirdly, the NEXOS management and the NEB certainly regarded that agreement as unsatisfactory and so did Mr Hughes, the Chairman of Logica. He described living under it as agony and has said, "Never again". To the impartial observer looking at that agreement, it does indeed seem to have flaws. It had no provision for amendment or for termination, except by agreement, it had no disputes procedure and the pricing arrangements over the first two years were on a cost-plus basis. Those are obvious flaws in the agreement. It is possible that we were additionally too much influenced by the views of the NEXOS management and of officials of the NEB in the importance we attached to the agreement. But the relationship between a marketing organisation and its principal supplier was obviously important. The fact that, for whatever reason, it was unsatisfactory was clearly important too. Where we were wrong was in ascribing to that agreement a critical importance in the failure of the company. As Mr Ford's report shows, the failure of NEXOS is attributable basically to the fact that it had built up a very heavy overhead cost: a sales organisation, a development organisation and a headquarters without having the sales or the certain expectation of sales to justify it. I apologise for being a little lengthy but it is an important point. Perhaps I could add just two further pleas in mitigation. First, the present report is based on a very full investigation and on access to material to which the Department would not normally have access, that is to internal NEB and NEXOS records. It is that additional knowledge which has led to a new judgment which I accept. Secondly, I did not in my former evidence attribute all the blame to the unsatisfactory nature of the agreement; I attributed it also to weaknesses of management in NEXOS.

2937. Is not one of the most important aspects of this the way in which the management changed the strategy which had been envisaged and accepted by the National Enterprise Board where they were moving from the sale of available products with a possibility of becoming later involved in further developments, into a situation where they were going to undertake imme-

[Chairman *Contd.*]

diate development and the sale of new products? So they turned what was a risky venture into one of higher risk and this is summarised in paragraph 1.4 of the report itself. Do you have any objection to that?

*(*Sir *Brian Hayes.)* It is a fair statement of what happened. The extent to which it was known to the National Enterprise Board and approved by them is a little obscure and Mr Ford's report makes that clear too. But there is no doubt that there was a subtle change in the strategy of NEXOS between the time when it was originally decided to set it up and about a year later. The change made the enterprise of higher risk because it was then a question of building up a very large marketing organisation in the hope of having a really good product to sell in very large quantity at an early date and to develop that product in partnership with Logica VTS over a very short timescale.

2938. Should not the alarm bells have rung immediately you moved from what was after all largely a selling organisation with the possibility of development, into one of immediate development? It was not a subtle change but a fundamental change.

*(*Sir *Brian Hayes.)* I suspect it did not appear to be a fundamental change at the time to the National Enterprise Board who were responsible of course for monitoring the company. I should perhaps make the fundamental point that the monitoring of NEXOS was a matter for the National Enterprise Board, the monitoring of the National Enterprise Board was a matter for the Department. The Department was at one remove from what was happening in the company. In defence of the NEB at that time one ought to point out that they were themselves under a good deal of stress. They had a change of chairman and membership at the end of 1979 and indeed over the whole period of the NEXOS venture they had no fewer than four chairmen and three chief executives. At the same time they were dealing with other matters of great importance—BL, Rolls Royce, Ferranti—and it is perhaps not too surprising that what was happening in NEXOS, if it rang a warning bell, did not ring it loud enough.

2939. In your covering letter you also refer to the letters that the Secretary of State received from the directors of NEXOS at the time approval was given for a further £13 million funding in February 1981. Should that not have been the second alarm bell and why were those letters not followed up?

*(*Sir *Brian Hayes.)* One says "second alarm bell" but alarm bells had rung in the Department a good deal before this; the Department had been concerned in the course of 1980 about what was happening in NEXOS and it was for that reason that no immediate decision was taken on the NEB's request for additional financing. Very rightly Ministers decided that they wished to look at the whole situation thoroughly before they took a decision on it. As to the letters of February 1981, I ought perhaps to say that I ought to have drawn attention to those letters in the notes which I gave to the Committee following the last evidence I gave. There the Department said that we were not in fact aware of the thoroughly unsatisfactory nature of the agreement between NEXOS and Logica VTS until later in 1981; in fact the unsatisfactory nature of that agreement was pointed out in one of the two letters that were sent to Sir Keith Joseph on 18 February 1981. That letter arrived in the Department late on 19 February and on the morning of 19 February Ministers of the Department met the Chairman of the National Enterprise Board and had discussed the whole NEXOS situation in the light of all the events that had taken place before then, of the prolonged study which the NEB themselves had undertaken in the summer and early autumn of 1980 and of the situation which the company was then facing. At that stage the Government had a choice effectively between only three options: one was to continue to drip feed NEXOS, which was in fact what had been happening since the late autumn of 1980, in the hope of finding further resources from the private sector; the second was to wind up NEXOS at once but closure would have been a costly process and indeed it proved to be later and the chance of recovering any significant part of what had already been invested would have been slim; thirdly was to organise additional funding which the National Enterprise Board was recommending and which would bring the total up to £35 million. Course three was the course adopted for what I regard as very good reasons at the time, and I can elaborate further on that if the Committee wish. But the fact is that that decision was effectively taken on 19

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February. The whole position in relation to NEXOS was discussed on that day very thoroughly by Ministers with the Chairman of the National Enterprise Board. So there is no question of the letters not sounding an alarm bell, the alarm bell had already sounded. The next question I suppose is why was not the proposal made in those letters—that Logica VTS should be taken over by NEXOS—followed up in the weeks and months immediately after the decision of mid February 1981. In making that proposal the directors of NEXOS had ignored one fact and that is that Logica VTS was an independent private sector company. Admittedly it was a company in which the National Enterprise Board had a substantial investment but it was a private sector company which had a supply and marketing agreement with NEXOS on which it was perfectly entitled to stand. There could be no question of the Government or the National Enterprise Board insisting that Logica VTS gave up its rights under the supply and marketing agreement or allowed itself to be taken over by NEXOS. So the view taken of the letters received from the directors of NEXOS at that time was rather that they were indicative of the difficulties of the management within NEXOS and of the strength of that management than a serious attempt to propose a course of action which was then practicable.

2940. But these were people closest to the action and they said that further funding should not be provided unless—which you say is very difficult to achieve—NEXOS and Logica were amalgamated. Looking back do you not think that their views should have received more weight?

*(*Sir *Brian Hayes.)* May I refer to their letter. In my view their letter is distinctly ambiguous. The first two pages of Appendix 10 to Mr Ford's report is the letter from Mr Moffat, Mr Wilkinson and Mr Hooton. That letter ends with two paragraphs, "I write to ask you for two things. Firstly for a very urgent decision to provide funding of up to a further £15 million on the understanding that we will not seek more." There is no question but that that request was the main purpose of the letter and that request of course was granted; the additional money was indeed approved by the Government on the day the letter was received. "Secondly for your . . . support in insisting on a merger of Logica VTS and NEXOS". That is not there made a requirement that has to be met before further funding is provided, indeed I am quite sure that had the directors of NEXOS been asked at that time whether they would wait for a decision on further funding until a decision had been taken on a merger of Logica VTS and NEXOS, they would have said certainly not. The fact was they had no money. They were in a situation of enormous difficulty then and unless further sums had been made available the company could not have continued trading for very much longer. I cannot believe that they would have insisted on the second of their points before the first should be granted. As I have pointed out, the second of their points is a very difficult one to achieve. Ministers were also influenced by the fact that they were informed at the meeting they had on 19 February that an independent chairman and two independent non-executive directors were being placed on the Board of NEXOS and that these would be able to take a clearer view than had been possible up to that date of the management of NEXOS itself and the problems it faced. It was in fact in the light of that knowledge that Ministers authorised the additional funds that were to be made available.

2941. The report provides very considerable evidence that the monitoring role of the National Enterprise Board was inadequate for the purposes of carrying out its task. As senior officials of the National Enterprise Board were on the NEXOS Board, how did they fail to notice what was going on? How did they fail to observe that the strategy had been materially changed, increasing the risks very substantially indeed?

*(*Sir *Brian Hayes.)* I had better not answer for the National Enterprise Board but refer that question to Mr Barker.

*(*Mr *Barker.)* Clearly I cannot answer that question from personal knowledge. It is concluded in the report from Mr Ford that this is an area in which NEB was not effective. These changes did happen, whether their significance was properly appreciated at the time is open to doubt but it is not clear. It is certainly clear that prior to the decision to recommend Government to invest the £15 million tranche, the then Chairman of the NEB and its Board at that time decided to have a very thorough appraisal of where the company stood,

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what it was trying to do and what the degree of risk was. This appraisal was conducted by three distinguished people brought in for that purpose and their report is described in some detail in Mr Ford's report. Clearly there was an awareness after the event of the change and of its significance. At that stage, however, the die was cast, the product was almost ready to go into the marketplace and I judge that my predecessors at that time took the view that since they had weathered up to that point the cash storm this was no point at which to withdraw before the product was actually tried in the marketplace.

2942. Are you saying that it is an inadequate method of providing control over the operations of the Board to appoint a nominee director or more than one nominee director in order to have information?

*(*Mr *Barker.)* For a complex business of this sort and a large investment, I believe monitoring should extend much more deeply than just the appointment of non-executive directors.

2943. What sort of monitoring would you recommend now?

*(*Mr *Barker.)* I would certainly be looking for a detailed operating plan with measurement of performance against that plan and regular comment whilst it is being exercised, very much in the same way that we now relate to the DTI.

2944. Are you confident that that is in practice what is happening in other areas of your activity?

*(*Mr *Barker.)* In relation to the two most significant remaining investments that is certainly happening now, yes. It is not happening in that degree of depth on the very large number of relatively small investments.

2945. I really cannot let this examination conclude without mentioning the question of the facsimile stocks. A large number of stocks of —878 facsimile machines appear to have been sold for a total of £1. Can you tell us at what price these were in fact sold and, if £1, why they were sold for such a very small amount?

*(*Mr *Ford.)* May I first make the point that I have not confirmed the number of machines included in the final sale but I do in my report quote a number—the one you referred to—which is the stock at the end of October. I should be extremely surprised if the final stocks sold were significantly different from that number of machines.

2946. Is this in Appendix 12?

*(*Mr *Ford.)* Appendix 12, paragraph 15.

2947. Could you make it clear how many of those stocks were sold for £1 and how many in transit were sold for a further £1?

*(*Mr *Ford.)* Approximately 878 were sold for £1 and a further number of machines, which were in transit, were also sold for £1. But I would suggest that it is misleading to say that they were sold for £1. They were not sold as a single transaction but were part of a complex agreement which represented the final wind-down of NEXOS, facsimile business and settlement of the position with Muirhead. There were claims by Muirhead Office Systems against NEXOS for breach of the supply and marketing agreement and both sides took legal advice as to the strength of their case. There were a number of other factors involved and I have been told that on the National Enterprise Board side there was concern to salvage an ongoing business and priority was given to preserving the ongoing business. The stocks were disposed of as part of this overall settlement. It is true that in the final agreement a monetary figure of a nominal £1 was assigned to the stocks on hand at the time the agreement was signed and a further nominal £1 to additional stocks which were still on order from Japan and were presumbly in transit at that stage. I would suggest that it would be misleading to place too much emphasis on that. One must see that that is just one part of an overall agreement and that either the agreement in total stood or it did not.

2948. The original cost of these facsimile machines was £1,820,000. They were sold for a total of £1 but the point that you are making is that this avoided paying compensation for the termination of the agreement.

*(*Mr *Ford.)* Yes, that is true. I would also add the point that the original cost is somewhat academic. NEXOS could not have sold those machines in my view at anywhere near the original cost.

2949. How much did Muirhead sell them for?

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*(*Mr *Ford.)* I do not know. We have not investigated that.

2950. What is your estimate as to the selling price of these machines?

*(*Mr *Ford.*) Probably in the region of £1,000 each but I really am guessing.

2951. So it is 878 machines at about £1,000 each, rather less than the cost but very much more than the nominal £1 which the NEB received for them?

*(*Mr *Ford.)* In saying £1,000 per machine I perhaps ought to confine that to the 6400 model and 6401 model, the Oki machines—the Japanese ones. The 6200 machines and the other machines were of Muirhead manufacture and it is fair to say that at that stage these machines were obsolete, or virtually obsolete and it was difficult to sell them at all. In saying £1,000 per machine one ought to attribute that to the 600 machines of Japanese manufacture.

2952. How did you become sure that the compensation would have been the amount you suggested at £700,000?

*(*Mr *Ford.)* I was not sure. We saw that the National Enterprise Board took legal advice. There was the possibility of damages against NEXOS. My own view is that in these circumstances it would have been very difficult to obtain anything for the machines if they had been sold. I know from my experience of liquidating businesses that it is extremely difficult to sell off stock in these circumstances. These are goods of a nature where the purchaser is looking to obtain spare parts in the future and service backup. It is not clear to me where a potential purchaser could have obtained that other than from Muirhead. The bulk purchaser would have had to make arrangements; Muirhead would almost certainly have had to be party to any agreements for the sale of these machines and therefore it seems to me that there really were no other options. It is therefore difficult to comment on the total settlement terms because there were no alternatives and therefore what the National Enterprise Board negotiated in the circumstances was probably the best they could achieve.

Mr Silvester

2953. Could I bring you back to this meeting on the 19 February 1981. As I understand it you say the letter arrived after the meeting had taken place with the Secretary of State?

*(*Sir *Brian Hayes.)* Yes.

2954. But this is not an unimportant letter, it is signed by the Managing Director, the Financial Director and the Marketing Director and it is one which contained a view which I would have thought would have been a major part of the discussion in which the Secretary of State was involved. Is that true or not?

*(*Sir *Brian Hayes.)* The Secretary of State himself was not involved in that discussion. Two other Ministers met Sir Frederick Wood on that day. The letters were in fact drawn to Ministers attention on the following day, which was before actual formal agreement was given to the £13 million. So it is not fair to say that they were not taken into account and indeed the content of the letters, though not the letters themselves, had obviously been part of the discussion of the overall NEXOS situation that Ministers had had with Sir Frederick Wood. I return to the point that Ministers had decided—I believe for good reasons—that it was right to agree with the National Enterprise Board's proposal that the further £13 million should be authorised. They did so in the knowledge that the Board of NEXOS was to be strengthened by the appointment of a non-executive Chairman of some distinction and of two non-executive directors and that those men would be looking at NEXOS, at its management, at its strategy and ensuring that the best possible course was pursued. In the light of that it would not have been right for Ministers to take up what was in fact the responsibility of the National Enterprise Board in relation to any dealings between NEXOS or the relationship between NEXOS and Logica VTS.

2955. I hear what you say but let us look at this letter a little further. It makes the suggestion that the additional money should not be made available unless the merger took place between Logica and Nexos. It goes on to say, ". . . which can only be achieved by strong resolve on the part of the Government and NEB". It seems to me that could well be consistent with these gentlemen knowing full well that it was a private company. We have had examples before of governments twisting arms of private companies if it was necessary to secure deals of this kind. When

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you read out the final paragraph you left out the word "explicit" before "support". Could you not read this letter as saying that the gentlemen involved, knowing the difficulties, nevertheless maintained additional money should not be available until this agreement had been sorted out by means of a merger?

*(*Sir *Brian Hayes.)* I do not believe that is what they were intending to say by this letter but had they in fact been saying that they would have been saying no more money for some considerable time. Even if that assumes that the merger could have been brought about by the process of leaning on Logica VTS—and that is a very questionable assumption—but even if one were to accept that assumption—it would clearly have taken a very considerable time to negotiate and during that time NEXOS could well have collapsed. It was a matter of the greatest urgency and indeed the letter itself says this, ". . . a very urgent decision to provide funding of up to a further £15 million".

2956. What were the good reasons that you were going to tell us about that the Minister had in mind when giving the £15 million?

*(*Sir *Brian Hayes.)* The choice at that time before Ministers was in fact three-fold. The first option was to continue to drip feed NEXOS, which is what had in fact been happening over the previous three months, in the hope that further resources would be found from the private sector. But that would not have restored the market's confidence in NEXOS, indeed it would have undermined its market prospects further and it would simply have led to a costly and lingering death. The second course was to wind up NEXOS at once but closure would have cost £5 million in itself and the chances of recovering any significant part of the £22 million already authorised for investment in NEXOS, most of which had already been spent, was very slim. The third option was to authorise the additional funding of £13 million which would bring the total authorised up to the £35.1 million envisaged in NEXOS's corporate plan of October 1980, the previous October. Course three, which was the course adopted, turned out to be a failure, but it certainly looked the best option at the time both to the National Enterprise Board and to the Government. Why? First, it has to be remembered that the sales of the 2200 which had just begun in January 1981 looked quite promising. That was the product on which the company's future had been gambled—if I may put it in those strong terms. It was just on to the market and it appeared to be doing well. Secondly, the exploration of possible private sector partners had revealed some interest which it was thought might lead to a deal in the second half of 1981 if the company continued to succeed in the marketplace. Thirdly, as I have mentioned already, the NEB told Ministers that they had appointed the three non-executive directors, including Mr Martin Harris as Chairman and that helped to remove anxieties which Ministers certainly felt over the NEXOS management. Finally, there had been an independent review carried out under Sir George Macfarlane's leadership the previous July to October which had culminated in a meeting at which Sir George expressed the personal view—it was not necessarily the recommendation of his entire team—that it would be right to continue to fund NEXOS until the end of 1981. He said it would be a high risk policy but that it might succeed but that any other policy would simply lead to early failure. So Ministers had very good reasons for regarding course 3 as the best but in order to limit the risk to public funds the NEB were told that if NEXOS were not succeeding commercially it would have to be closed down with the total cost contained within the additional £13 million then authorised. The NEB were also asked to provide the Department with an assessment of NEXOS's prospects and their views on the quality of NEXOS's senior management and finally, to press ahead with talks with private sector partners as rapidly as possible. So given the then state of the company, given the entry of the 2200 onto the market to a certain degree of acclaim, it seemed right to continue to back NEXOS for a limited period and with a limited amount of money in the hope that its success would attract private sector partnership and in the hope of avoiding what were clearly the heavy costs of closing the enterprise down.

2957. The conclusion of all this in Mr Ford's report is that it was essentially a misjudgment by the management of their operating plan which was involved in this agreement. But I am still worried about the

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agreement and I should like to ask you both what you think is meant by this sentence in the same letter to which we have been referring in Appendix 10. In paragraph 3 it says, "The collapse of NEXOS could be seen to result directly in a large financial benefit to certain suppliers, notably Logica VTS Limited, who thus have a vested interest in our demise." What does that mean?

*(*Sir *Brian Hayes.)* I do not know that I can interpret what the directors of NEXOS meant. I suppose they meant that if NEXOS itself died then the rights in the 2200 would belong entirely to Logica VTS, that this was a machine with prospects in the market and that Logica would then be able to exploit it for their own benefit only. I assume that is what they meant but I cannot say what was in their minds.

*(*Mr *Ford.)* My view is the same as that expressed by Sir Brian. At this stage the directors of NEXOS had recently taken Counsel's opinion on the ownership of the product rights in the 2200 wordprocessor and hoping, it appears, that Counsel would be of a view that the rights belonged to NEXOS. In the event the opinion received was not one satisfactory to the management of NEXOS and it was rather vaguer. My own view of the supply and marketing agreement is that if NEXOS had gone under Logica would have been free to make the machine and make arrangements for another sales outlet. The machine at this stage, of course, had been developed using NEXOS funds under the supply and marketing agreement. It does seem that at this particular point Logica would have had an interest in seeing NEXOS go under.

2958. So that is a reasonable statement on the part of the directors at that time in your view?

*(*Mr *Ford.)* Yes.

2959. Does that not to some extent then conflict with the conclusion of your report which tends to diminish the significance of this agreement in the working relationship between Logica and NEXOS?

*(*Mr *Ford.)* No. There is a difference of opinion between myself and certain of the former executive directors of NEXOS as to why NEXOS collapsed. I see them as having pursued a very high risk policy during 1980 which in my view I do not consider they should have followed. I think they should have taken a more cautious approach and not built up the size of the organisation until the 2200 had been introduced to the market and they could see the level at which it was selling. They took a different path and it was that other path which put the company into a situation where, when the 2200 sales did not take off it was bust. At the time the directors wrote this letter they suspected that further finance would not be available and that the company might well go under and I suspect that that lay behind this paragraph in the letter.

Sir Michael Shaw

2960. If we look at the letter dated 18 February in Appendix 10 it is signed by three directors: the Managing Director, the Financial Director and the Marketing Director. How long had they been in their positions of responsibility?

*(*Mr *Ford.)* Mr Moffat, the Managing Director, had been appointed in January 1979, so that would make just over two years. Mr Wilkinson had been appointed in August 1979 and Mr Hooton had been appointed at the beginning of January 1980, so just over a year for Mr Hooton.

2961. So how far would these gentlemen have been involved in the basic strategy of NEXOS?

*(*Mr *Ford.)* Mr Moffat very much so, very much involved. Mr Wilkinson came on the scene at a time when there appears to have been some shift in the direction of NEXOS. By the time Mr Wilkinson came on the scene the decision had been made not to take on the sales of the then existing Logica wordprocessor and it was also clear that Muirhead's existing facsimile machines were obsolete. He also came on the scene at the time, or immediately after, the proposal to license the Delta machine and also to buy the service organisation UDS.

2962. After that?

*(*Mr *Ford.)* Yes, immediately after that. By the time Mr Hooton joined the company the Development Director was in place and was building up his department and the range of development projects was largely in place. Most of the changes had taken place by the time Mr Hooton joined the company.

2963. In a sense therefore, possibly with the exception of Mr Moffat, they were not directly responsible for the line of develop-

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ment that was decided upon by NEXOS?

*(*Mr *Ford.)* In some ways no, they were not, but in other ways they were. Mr Moffat obviously, as Managing Director and having been there since day one, clearly must be. Mr Wilkinson was Financial Director and therefore one would expect him to be monitoring the expenditure pattern in the company, to be aware of what funds had been committed to the company by the NEB and one would expect him to have had cash flow forecasts so that he could see to what extent the company's future plans were covered by committed funds. One would expect him, as Finance Director, to be constantly monitoring cash-flow projections. So to that extent he must bear some responsibility. Mr Hooton appears to have been the person who was responsible for building up the sales organisation. I am critical of the buildup of the total organisation, including the head office operation, but a large part of the buildup was indeed the sales organisation for which Mr Hooton had responsibility. To that extent I would include him in the net of responsibility.

*(*Sir *Brian Hayes.)* It is important, in looking at the view taken of the letter of 18 February, to recall what had happened in the second half of the previous year. In July of 1980 the NEB had made it clear to NEXOS that they had for the time being, indeed until the end of the year, to live within the monies already authorised and those monies were £15.8 million. In fact NEXOS continued to expand, despite that knowledge and indeed increased its staff by 100 between the end of June 1980 and the end of December 1980. It then ran out of money in November 1980, which indeed was not surprising and in the light of that history it is perhaps not surprising that Ministers regarded these letters more as an indication of the calibre of NEXOS management than of what ought to be done for the future.

2964. It is clear from what you say that when the development took place at the back end of 1980 these gentlemen were of course in place and active; it is important to remember that. We now come on to the letter of 17 February from the Financial Director himself. He seems to indicate on page 2 that, "For many reasons, . . . the NEB did not carry out their essential role in the Nexos venture" so it appears to be the NEB's fault. Is it fair to say that Mr Wilkinson seems to shift the blame onto the NEB there?

*(*Sir *Brian Hayes.)* Certainly, yes, it does indeed bear that interpretation.

2965. So far as the Department is concerned, if we follow on the correspondence, clearly the letters have been discussed with the NEB and the Ministers so that they were taken into consideration. It would appear from the replies that have been given that the full responsibility and indeed trust of the Department was placed on the NEB in this matter?

*(*Sir *Brian Hayes.)* That is right. It raises again this general question of what were the responsibilities of the NEB on the one hand and the Department on the other. One has to remember that the NEB was appointed to do precisely the sort of thing it was doing in this instance. It was a body largely composed of businessmen and it was there to monitor and to help run businesses. The Department is composed of civil servants and we are not supposed to have these commercial skills which businessmen have. It would have been presumptuous for mere bureaucrats to instruct the National Enterprise Board on how to run a company.

2966. One can only ask what lessons have been learned from this little incident?

*(*Sir *Brian Hayes.)* A number of lessons. The lesson that the present Government would draw is that this is not the sort of activity it is sensible to conduct, that in fact the National Enterprise Board's attempt to set up wholly in the public sector a new company to plug a gap which was believed to exist in the economy was a misguided one. But of course that is a matter of general policy and the fact is that the National Enterprise Board was operating in 1978 when this story began under another Government and under quite different policies. There was nothing improper in what the National Enterprise Board did which was to pursue policies it was intended to pursue. The second lesson is that the monitoring of a company and of an investment is a very difficult business which needs a large amount of attention and may not have attracted all the attention it needed from the National Enterprise Board for very understandable reasons during the difficult days of 1979 and 1980. The third lesson I would draw is that in general it is better that the people who monitor investments should not themselves

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be involved in the actual management of those investments. In this case the monitoring was in fact run by two officers of the National Enterprise Board, one of whom was serving for much of the time as Chairman of NEXOS and the other as a director. Although this meant they had the great advantage of knowing the situation inside out, it would have been difficult for them to stand back from NEXOS and see it with a wholly objective and impartial eye. In principle it is generally best that the task of monitoring should not be given to somebody deeply engaged in the project being monitored.

2967. If a big investment company had this amount of money to invest is it thought that it would invest £13 million or £15 million in this way?

*(*Sir *Brian Hayes.)* No. Under the present Government there is no question of entering into this kind of investment or indeed of permitting the National Enterprise Board to do so. The British Technology Group has very different aims now and is subject to a different style of monitoring from that which existed at the time of NEXOS.

Mr Deakins

2968. One of the difficulties that this Committee have had is that the C&AG has not had access to the records of the NEB and NEXOS. Would you feel that is something that perhaps ought to be remedied for the future in that had he has such access it might well have been that the Committee could have made reports much earlier in the light of these projects which might—I stress "might"—have helped things rather than the outturn which has happened?

*(*Sir *Brian Hayes.)* I think I ought not to express an opinion on that because it is a matter that extends much more widely than the NEXOS question. It turns on the whole question of the extent to which the NAO should have access to bodies outside Government. It is better that I should not comment on that wider question of policy.

2969. But the Department has been able to employ a distinguished accountant, Mr Ford, from the private sector, who has had access to these records. Is it not astonishing, quixotic—I do not know quite what the appropriate word is—that the C&AG, Parliament's watchdog, should be denied access and yet an eminent outside accountant should have been able to have access?

*(*Sir *Brian Hayes.)* It was quite proper that our accountant should have access to conduct an investigation which had been requested by this Committee. To that extent I suppose, admittedly at one or two removes, the Committee has had the advantage of access through Mr Ford to the papers of the NEB and of NEXOS. But I would prefer not to comment on the wider policy question of the extent to which the NAO should have access to papers outside Government.

2970. Could I now turn to the individuals concerned. I do not wish to know the names of anybody; I am not interested in names but in principles. Does your Department know the names of the people responsible for drawing up the agreements between NEXOS and Muirhead and NEXOS and Logica?

*(*Sir *Brian Hayes.)* I am sure Mr Ford does but I do not.

*(*Mr *Ford.)* Yes, I think we do. I am not 100 per cent certain but pretty certain.

2971. We know of course the names of the people responsible in the NEB at the appropriate times in its history?

*(*Mr *Ford.)* Yes.

2972. We also know the names of the people responsible in NEXOS?

*(*Mr *Ford.)* Yes.

2973. Fine. So there is a list of names of people who bear some responsibility for this fiasco, for this loss of public funds. There is in the Civil Service in every department a list of names of people known as the list of "the great and the good". Everybody knows the list to which I am referring. From this list people are culled from time to time and take on distinguished appointments in the public sector or in the fringes of the public sector. Can you give us an assurance that the names of none of the individuals concerned in any of the organisations currently appear on that list of the great and the good?

*(*Sir *Brian Hayes.)* No, I cannot give that assurance because I do not myself know the names. Could I make one general point, that the NEXOS venture which failed was a high risk venture. The NEB at that time was in business to go into high risk ventures. It could not expect every venture

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it undertook to succeed and it would be wrong to say everybody connected with a venture which failed should be blackballed for ever more thereafter. It also seems to me that the responsibility for the failure of NEXOS is spread quite widely.

2974. You would not then make any distinction between individuals concerned, you would almost whitewash them all on the grounds that this was a high risk venture and that therefore no real blame can be attached to any of them? I find that attitude, if that is your attitude, astonishing.

*(*Sir *Brian Hayes.)* No, I do not say that. Some blame can be attached here and there. I was simply trying to see that blame in perspective. It may be simply that mine is not a punitive nature but I do in fact see the difficulties under which everyone concerned was operating in this venture. What happened was that the management of NEXOS took a gamble. Had that gamble come off we would all be saying it was a brilliant piece of entrepreneurial drive; it did not come off. It was an unwise gamble and blame does attach to them, since this was public money, for taking it but I can understand the reasons why they took it.

2975. When people take gambles with their own money they lose or they win but when they take gambles with public money what you seem to be saying—on behalf of your Department if not the Government—is that it is just unfortunate because these are high risk projects and one must expect some failures. Surely to goodness people who have such a record of failure, even in such a high risk area, should not then be available as names to be chosen by another unfortunate department that might wish to employ people for a certain project, nothing to do with this at all? Nothing may be known about the background here but they appear on the list of the great and the good or some other list in the Government service and so, without regard to their failure in this case, they are re-employed in the public service looking after public funds. Is that not wrong?

*(*Sir *Brian Hayes.)* Although I do not know whether any of these names appear on any lists of the great and the good, when names do appear on such lists their curriculum vitae and their record appear with that name. Their involvement in that case in NEXOS and the degree of responsibility that may be attached to them for NEXOS's failure would most certainly appear there and be taken into account in any decision whether to employ them further.

2976. Presumably then, since you do not know the names, you could not actually give us an assurance that none of the people concerned with responsibility for this fiasco is currently employed in the control or disbursement of public monies anywhere?

*(*Sir *Brian Hayes.)* I cannot give that assurance because I just do not know.

2977. Could I turn finally to the lessons; ignoring the first lesson which is a matter of the philosophy of the current Government, which one accepts as that is the Government's philosophy which it was elected to put into effect. There were two other lessons which you drew: you said that monitoring is difficult and needs a great deal of attention and did not get enough attention in this case but this lack of attention was understandable—those were your words. That seems to me to be excusing a lack of attention. We are dealing here not with lowly paid people but we are dealing with very highly paid people. When people are paid high salaries there is a commensurate degree of responsibility. It does seem to me that on behalf of the public service and as the Accounting Officer for the Department's use of money you are almost excusing what I regard as absolutely inexcusable behaviour.

*(*Sir *Brian Hayes.)* I was talking then of the monitoring by the National Enterprise Board. When I said it was understandable that what was happening in NEXOS did not ring enough bells early enough, I was really referring to the fact that there had been drastic changes in the Board—indeed the entire Board resigned and a new Board had to be appointed—that there had been changes at the Chief Executive level, that the future of the Board itself was uncertain and that it was conducting simultaneously a number of other much more important exercises than the NEXOS one. In those circumstances I can understand—I do not excuse but I can understand—the failure of NEB to monitor adequately what was happening in NEXOS.

2978. I am concerned to learn the lessons for a possible future Government because you have rightly made the point that the

[Mr Deakins *Contd.*]

present Government certainly will not have this sort of thing happening again because of its philosophy, but you may have a change of Government at some point in the future with a different philosophy. I am concerned that these lessons are very clearly on the record so that any future Government picking up the pieces and starting on a new track, whether in DTI or elsewhere will be able to appreciate the full impact of the lessons from this fiasco?

*(*Sir *Brian Hayes.)* I am sure a future Government will do so. Mr. Ford's report of course will be public property and the lessons emerge rather clearly and starkly from it. There is also a degree of continuity on the part of the civil servants at the Department of Trade and Industry which will ensure that these lessons are not forgotten.

2979. Your final lesson that those who monitor should not be managers, which is very important indeed, is presumably a lesson not merely for DTI but the whole of the Government service because there must be other Government departments which sponsor industries which might in the future be involved directly or indirectly in monitoring what is going on in private industry which has access to public funds. I would hope that the lessons from this will be conveyed to all departments in the Government service. Is that being done, and if so, how?

*(*Sir *Brian Hayes.)* It will be done of course because the report of this Committee will be available to all departments. I may well draw the attention of other departments to the lessons to be learned.

Sir Peter Hordern

2980. My recollection of the relationship between the National Enterprise Board and the Minister is somewhat different from that of Sir Brian. Sir Brian has said, with characteristic modesty, that mere bureaucrats were not involved in any way with the National Enterprise Board. But my recollection of Sir Peter Carey when he held this particular post is somewhat different. I do not know whether you can remind me at short notice what it was but I have a recollection that Sir Peter Carey used to talk about regular meetings and reports and reports back from the NEB, from Lord Ryder in those days, about other companies who had gone bust within the NEB and how unlikely this was to occur again because of the very close relationship which existed between Lord Ryder and Sir Peter Carey. Do you have any particular recollection of those relationships which existed at that time, in contrast with what Sir Brian has outlined as the relationship which he has?

*(*Sir *Gordon Downey.)* My recollection is very similar to yours in that I did understand there to be a fairly regular dialogue between the Department and the NEB. I dare say this has varied over time and no doubt the principle of the "hands-off" relationship emerges more strongly at some times than others. I do not know whether Sir Brian has actually said that there was no continuing dialogue; I am not sure that he has.

*(*Sir *Brian Hayes.)* No, I did not indeed. There is a very substantial continuing dialogue which continues to follow the principles laid down by Sir Peter Carey in a letter to this Committee on 16 June 1980. In this Sir Peter said, "The Department does not duplicate any of the routine monitoring undertaken by the NEB" and it was to that that I was alluding. "The Department's monitoring of the NEB's activities is directed primarily at ensuring that the NEB's own monitoring of their companies operates satisfactorily".

2981. That is what I rather thought Sir Peter's statement said though it was made some time ago. So Sir Peter said that the monitoring by the Department of the NEB was to monitor the NEB's activities but it now appears that the NEB was not monitoring the activities of NEXOS and if what Sir Peter was saying is correct, it would appear that the Department was not monitoring the affairs of NEXOS at all.

*(*Sir *Brian Hayes.)* The Department did not monitor directly the affairs of NEXOS; it did monitor the NEB's own monitoring of NEXOS.

2982. That is again what I rather thought was the position. Then how comes the situation that when the NEB were shown not to be monitoring NEXOS at all —maybe that is a bit too strong—or very little, because you said that within six months they took on 100 people without apparently the NEB raising any questions, the Department's monitoring of NEB was satisfactory when the NEB's monitoring of NEXOS could allow them to engage 100

[Sir Peter Hordern *Contd.*]

people without anybody questioning the matter?

*(*Sir *Brian Hayes.)* The Department's responsibility was to ensure that the NEB's own procedures for monitoring investments were adequate and effective and that the Department did. We have in fact periodically received reports as to the outcome of scrutinies by the NEB's own auditors of their monitoring procedures. We received one such report in April 1979 just when this whole business had started and its conclusions were that the auditors were generally satisfied that the NEB's monitoring procedures were adequate, that the information being received was being subjected to critical scrutiny and that danger signals were being acted upon. That was the information given to us by the NEB's auditors in April 1979.

2983. Was that before or after NEXOS?

*(*Sir *Brian Hayes.)* That was after the beginning of NEXOS. NEXOS began trading in January 1979.

2984. I think you said it was in July that they started to recruit and that between July and September 100 people were recruited?

*(*Sir *Brian Hayes.)* That was in the following year, it was not when they started to recruit. They actually added to their numbers 100 between July and December 1980 and I alluded to that only because it seemed to me rather symptomatic of the attitude of the management at a time when they knew the company was in financial difficulty and when the amount of money available to them was strictly limited to the amount that Ministers had approved.

2985. It does seem to me that the accountant's report, which might have been very valid before July—it might have been valid in January of that year—was certainly not valid after July when recruitment took place. Would you say that that description by the auditor of the management practices of NEB could be sustained in view of what happened later?

*(*Sir *Brian Hayes.)* I do not think one could fairly say that the monitoring of NEXOS was impeccable.

Sir Peter Hordern: No, I think less; one might even go as far as to say it was peccable.

Mr Campbell-Savours

2986. Is it not true that in 1979 there was a very great change in morale within the National Enterprise Board? Firstly, there was a high turnover of staff, secondly, there was a loss of direction by many employees in the sense that they felt they did not know where they were going, thirdly many people felt that the National Enterprise Board had become almost a managing agency for British Leyland and a combination of these difficulties within the National Enterprise Board may have been responsible to some extent for the failure to perhaps notice what was going on in a way which hitherto they may have done?

*(*Sir *Brian Hayes.)* It is perfectly true that the Board was operating under difficulties and in a state of uncertainty about its future. Indeed that was the point I was seeking to make earlier, not necessarily to excuse but to explain what happened in relation to its monitoring of NEXOS.

Chairman: Thank you for giving evidence today.

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HOUSE OF COMMONS

Twelfth Report from the

COMMITTEE OF PUBLIC ACCOUNTS

Session 1985–86

The Common Agricultural Policy: achievements and problems

Ministry of Agriculture

Ordered by The House of Commons *to be printed*
29 January 1986

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The Committee of Public Accounts is appointed under Standing Order No 98, viz:

Committee of Public Accounts

98.(1) There shall be a select committee to be called the Committee of Public Accounts for the examination of the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit, to consist of not more than fifteen members, of whom four shall be a quorum. The committee shall have the power to send for persons, papers and records, to report from time to time, and to adjourn from place to place.

(2) Unless the House otherwise orders, each Member nominated to the committee shall continue to be a member of it for the remainder of the Parliament.

The cost of preparing for publication the Shorthand Minutes of Evidence taken before the Committee was £461.11.

The cost of printing and publishing this Report is estimated by Her Majesty's Stationery Office at £2,592.

THURSDAY 7 JULY 1983

The following were nominated as members of the Committee of Public Accounts:

Mr Dale Campbell-Savours
Mr Eric Cockeram
Mr Peter Hordern
Mr Michael Latham
Mr Robert Maclennan
Mr John Maxton
Mr Michael Morris
Mr Richard Needham
Mr William O'Brien
Mr George Park
Mr Nicholas Ridley
Sir Michael Shaw
Mr Barry Sheerman
Mr Robert Sheldon
Mr Michael Shersby

Mr Robert Sheldon was elected Chairman, 13 July 1983.

Subsequent changes in the membership of the Committee have been:

25 October 1983: Mr Richard Needham and Mr Nicholas Ridley discharged; Mr John Moore and Mr Fred Silvester appointed.

8 December 1983: Mr Barry Sheerman discharged; Mr Eric Deakins appointed.

1 February 1985: Mr John Maxton discharged; Dr John Marek appointed.

5 December 1985: Dr John Marek discharged; Mr Allan Rogers appointed.

The present composition of the Committee is:

Mr Robert Sheldon, Chairman

Mr Dale Campbell-Savours
Mr Eric Cockeram
Mr Eric Deakins
Sir Peter Hordern
Mr Michael Latham
Mr Robert Maclennan
Mr John Moore
Mr Michael Morris
Mr William O'Brien
Mr George Park
Mr Allan Rogers
Sir Michael Shaw
Mr Michael Shersby
Mr Fred Silvester

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TWELFTH REPORT

The Committee of Public Accounts has made further progress in the matter referred to it and has agreed to the following Report:

THE COMMON AGRICULTURAL POLICY: ACHIEVEMENTS AND PROBLEMS

Introduction

&AG's port, HC '8, para 2

1. The Common Agricultural Policy (CAP) of the European Community absorbs about two thirds of the Community's budget; and because the United Kingdom (UK) is among the Members with the lowest agricultural content in their gross domestic products, it receives a correspondingly low share of CAP funds and is a substantial net contributor to the Community. In 1983 the UK received £1,085 million under the CAP but was a net contributor of nearly £600 million to the Community.

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2. We took evidence from the Ministry of Agriculture, Fisheries and Food (MAFF) on a report by the Comptroller and Auditor General (C&AG) on the achievements and costs of the CAP in the UK. In doing so we recognised that changes to the CAP can only be introduced through proposals by the European Commission and decisions of the Council of Ministers. It is however open to the UK to press for change through this decision-making process. Our examination was therefore particularly concerned with MAFF's role in monitoring the effects of the CAP and considering what changes in CAP measures might be in the best interests of the UK and the Community as a whole.

CAP Objectives

&AG's eport, paras -6

3. The declared aims of the CAP, embodied in the Treaty of Rome in 1957, are to increase agricultural productivity; to ensure a fair standard of living for the agricultural community; to stabilise markets; to assure the availability of supplies; and to ensure that supplies reach consumers at reasonable prices. But no Community document has sought to interpret these broad aims into more specific, quantified objectives or to define where priorities should lie between aims which may be in conflict.

s 218, 221, 32, 237, 273

4. MAFF told us that the CAP objectives were similar to those of the 1947 Agriculture Act in the UK, and that they did not think that amending the Treaty in the light of changed circumstances since 1957 would be helpful. Different Members placed different emphases on the relative weights to be given to the objectives, and each country had its own national objectives. MAFF were therefore more interested in securing more specific targets where these would accord with UK national objectives than in reviewing the general statements in the Treaty.

) 218

CAP Achievements and problems

'&AG's eport, para 1, Appendices and 2

5. The measures used under the CAP are of two types. Guarantee measures, accounting for the vast bulk of CAP expenditure, are designed to regulate agricultural markets by supporting commodity prices and giving protection against imports to the Community; and guidance measures give financial support for investment designed to improve the structure of the farm sector and for farming in Less Favoured Areas.

C&AG's report para 40

6. While recognising the difficulty of assessing the effectiveness of these measures in the absence of well-defined objectives, the C&AG's report considered the evidence available as to the achievement of the aims stated in the Treaty of Rome. It noted that under the CAP farming had achieved significant increases in production and yield, particularly in cereals and milk; labour productivity had improved by 49 per cent between 1973 and 1983; average farm incomes fell initially, but had recently improved similarly to those outside agriculture, though with wide variations between sectors and regions; supplies to consumers had been assured; and food prices had fallen in real terms, significantly since 1979, albeit generally remaining above world market prices.

C&AG's report paras 22, 29–33, 40

7. Against these benefits, uniform guarantee prices had tended to over-support large-scale producers in order to sustain economically less viable farms; inability to control surplus production had led to mounting stocks of cereals, beef and milk products in intervention storage; the costs associated with these surpluses, together with the high level of guaranteed prices, represented a significant transfer of resources from the consumer and taxpayer to the agricultural sector at the expense of other sectors of the European economy; higher productivity had tended to reduce the demand for labour in rural areas; and there were doubts about the effectiveness of control over growing national aids to farming which could lead to unfair competition.

Steps taken to deal with problems

C&AG's report para 35

8. For several years the European Commission, in advising the Council of Ministers, has sought with limited success to discourage surplus production by holding down the level of price support. The UK favours this as being the most effective means of restricting production as well as encouraging consumption through lower consumer prices. But compromise decisions reached in the Council have so far failed to curb prices sufficiently to achieve significant reductions in production, and MAFF told us that in their view this mechanism had not worked because it had not yet actually been tried. For example, over the past four or five price fixings for wheat the price had been reduced in real terms by about 12 per cent; but there had been a growth in productivity of 29 per cent, so that the farmer's real return per hectare had still increased by 14 per cent. MAFF also told us that they were looking at other options for controlling surplus production, including the introduction of quotas.

Qs 247, 252, 257, 267

Q 247

Q 253

C&AG's report para 38

9. For two products, sugar and milk, the Community have introduced quota systems for controlling production (we are also aware that in the United Kingdom there is a planned acreage scheme for potatoes to limit output). Even so, the supply of milk in the Community still exceeds demand by 15–20 per cent, and MAFF pointed out that, although there were obvious advantages in the quota option, in that it operated quickly and could be controlled, this mechanism had the limitations of cutting back both efficient and inefficient production, of tending to freeze the pattern of production and of not stimulating consumption. It could also open the way to administrative discretion which might not be operated consistently by all Members.

Qs 245, 255–7

C&AG's report para 39

10. The Community is now also attempting to restrain the rising cost of the CAP by adopting a "budgetary discipline" which includes a "financial guideline" applying for the first time to expenditure falling in 1986. This provides for expenditure on market support to grow more slowly than the

Q 223

Community's financial resources and for the Commission to propose economies to ensure that expenditure is kept within the ceiling approved by the Council. However, the guideline allows the Council to take account of undefined "exceptional" circumstances in applying the agreement.

Q 228

11. MAFF also told us that the European Commission had published a Green Paper in June 1985 entitled "Perspectives for the CAP". This was an options paper for discussion by governments and interested organisations. Recognising that current policies producing surpluses could not go on, it favoured a tougher and more market-orientated price policy. MAFF's general reaction was therefore reasonably favourable and they were awaiting more specific proposals which the Commission was preparing.

Q222

12. A necessary precondition for a reduction in surpluses is that some currently productive land has to be diverted to different use. MAFF told us that this had been a matter of concern to them and that they and the Economic and Social Research Council had commissioned a number of studies into the options available. One of the areas of current interest was the scope for increased growth of woodland.

Comments and conclusions

13. We accept that the omission of the European Community's policy making bodies to refine the broad aims of the CAP in the Treaty of Rome into more specific and quantified objectives reflects the reality that CAP measures are determined by a consensus among Ministers of Member States with in some respects competing national objectives. Nonetheless, the lack of precision in agreed objectives is contrary to a generally accepted basic principle for ensuring the effective use of public money, and has in our view contributed to the indefensible situation in which by early 1985 over 15 million tons of surplus commodities were held by the

C&AG's report, Table 6

Community in intervention storage including, in the UK, nearly four million tons of cereals, 134,000 tons of butter and 50,000 tons of beef.

14. We believe that a distinction can be drawn between changing the fundamental aims in the Treaty of Rome and seeking better control over the direction of CAP measures by agreeing specific targets or criteria

Q 218

linked to the existing general aims. We note MAFF's acceptance of the desirability of the latter where it accords with UK interests and we trust that they will press strongly for progress in this direction in future negotiations.

15. We share the European Commission's and MAFF's anxiety at the growing financial cost of the CAP. We regard the introduction of a budgetary discipline and financial guidelines as significant steps towards improved control over total CAP expenditure, although they will not in themselves ensure, without better definition of objectives and priorities, the most cost-effective use of the funds made available. We trust that MAFF will remain vigilant against any tendency by the Community to soften this discipline by excessive use of exception clauses.

C&AG's report, paras 22, 46–7

Q 247

16. The C&AG pointed out in his report that the main instrument of the CAP, the guaranteed price mechanism, seemed to be falling between two stools in trying to regulate the market as well as to provide support for less viable farming units; and MAFF's evidence suggested that cereal price fixings in recent years, in particular, had been generous towards large scale cereal farmers. The C&AG's view that the way forward was to try to separate market regulation measures from income support for social reasons has proved to be in harmony with the theme of the Community's Green Paper. This general principle also gained cautious acceptance by MAFF, whose reservations were based on the possibility that the UK might be a net financial loser if income aid to poorer farmers were provided by the Community, and on the fear that it might increase the scope for unfair competition if it were left to be provided on a purely national basis. The Ministry agreed that any income aids for social reasons would have to take account of the non-agricultural income of part-time farmers.

Q 228

Qs 226–7, 244

Qs 229–30, 238

Q 277

17. We accept that the separation of market regulation and social objectives needs to be approached with caution. But we believe that it ought to be beneficial for the Community as a whole in reducing the total burden of price support, and that, this being so, it should be possible for the UK in negotiation to ensure that some net benefit accrues to this country. For example, we do not see it as axiomatic that income support for selected farmers should come either from the CAP or from national measures: it could equally well come from a possibly enlarged European Social Fund, where it would have to compete for priority with other support for social purposes for which UK claims might be greater.

Q 222

18. We welcome MAFF's assurance that they are considering possible ways in which land now used to produce surpluses could be diverted to other uses. We think it important that alternative uses should be explored, and cost-effective measures devised to encourage them, as a matter of urgency; and we recommend that MAFF should pursue this issue vigorously, both nationally and with the European Commission.

19. We fully recognise the difficulties and complex issues involved in negotiating among a large group of nations a pricing and subsidy régime which will keep the market in reasonable balance, avoid over-drastic changes to farming communities and provide an acceptable compromise between conflicting national interests. But we are deeply concerned at the failure so far to stem the high costs of the CAP, including its mounting commodity surpluses. We therefore urge MAFF to use every opportunity to support and advocate changes, some of which are already in prospect, designed to distinguish more clearly between market regulation and social objectives, to bring support prices closer to world market prices, and to encourage the diversion of land use away from the production of surplus commodities. We also welcome the continuing consideration which is being given by MAFF to other options for restraining surplus production, including quotas.

20. In this Report we have looked generally at the consequences in the UK of the CAP and the factors which have contributed to them. In view of the substantial resources which are consumed by the CAP, we intend to take further opportunities to examine particular aspects in greater depth.

SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

21. (i) The lack of precision in the agreed objectives of the CAP is contrary to a generally accepted principle for ensuring the effective use of public money (paragraph 13);

(ii) We trust that MAFF will press strongly for progress in agreeing specific targets or criteria linked to the general aims of the CAP in the Treaty of Rome (paragraph 14);

(iii) We regard the introduction of a budgetary discipline and financial guideline as significant steps towards improved control over CAP expenditure; and we trust that MAFF will remain vigilant against the softening of this discipline by excessive use of exception clauses (paragraph 15);

(iv) We accept that the separation of market regulation and social objectives needs to be approached with caution; but we believe that it ought to reduce the Community's total burden of price support and that it should be possible for the UK in negotiation to secure some net benefit (paragraph 17);

(v) We welcome MAFF's assurance that they are considering ways in which land now used to produce surpluses could be diverted to other uses; and we recommend that they should pursue this issue vigorously, both nationally and with the European Commission (paragraph 18);

(vi) We urge MAFF to use every opportunity to support and advocate changes designed to distinguish more clearly between market regulation and social objectives, to bring support prices closer to world market prices, and to encourage the diversion of land use away from the production of surplus commodities (paragraph 19).

(vii) We welcome the continuing consideration by MAFF of alternative options for restraining surplus production including quotas (paragraph 19).

(viii) We intend to take further opportunities to examine particular aspects of the CAP in greater depth (paragraph 20).

PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT

WEDNESDAY, 20 NOVEMBER, 1985

Members present:

Mr Robert Sheldon, in the Chair

Mr Eric Cockeram
Mr Eric Deakins
Sir Peter Hordern
Mr Michael Latham
Mr Robert Maclennan
Mr William O'Brien
Mr George Park
Sir Michael Shaw

Mr H D Myland, Deputy Comptroller and Auditor General, was further examined.

The Committee deliberated.

* * * *

Mr C H A Judd was called in and further examined. Mr R Butt, Assistant Secretary, HM Treasury, was called in and examined.

The Comptroller and Auditor General's report on achievements and costs of the Common Agricultural Policy in the United Kingdom was considered.

Sir Michael Franklin, KCB, CMG, Permanent Secretary, Ministry of Agriculture, was called in and examined.

[Adjourned till Monday next at a quarter to Five o'clock.

* * * *

WEDNESDAY, 29 JANUARY, 1986

Members present:

Mr Robert Sheldon, in the Chair

Mr Dale Campbell-Savours
Mr Eric Cockeram
Mr Eric Deakins
Sir Peter Hordern
Mr Michael Latham
Mr Robert Maclennan
Mr William O'Brien
Mr Allan Rogers
Sir Michael Shaw

Sir Gordon Downey, KCB, was further examined.

The Committee deliberated.

Draft Report (CAP: achievements and problems), proposed by the Chairman, brought up and read.

Ordered, That the Draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 7 read and agreed to.

Paragraphs 8 and 9 read, amended and agreed to.

Paragraphs 10 to 17 read and agreed to.

Paragraphs 18 and 19 read, amended and agreed to.

A paragraph—(*The Chairman*)—brought up, read the first and second time, amended, and added (as paragraph 20).

Paragraph 20 (now 21) read, amended and agreed to.

Resolved, That the Report, as amended, be the Twelfth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 92 (Select committees (reports)) be applied to the Report.

* * * *

[Adjourned till Monday next at a quarter to Five o'clock.

LIST OF WITNESSES

Wednesday, 20 November, 1985

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Sir Gordon Downey, KCB, Comptroller and Auditor General, Mr C H A Judd, Treasury Officer of Accounts, and Mr R Butt 1

MINISTRY OF AGRICULTURE

Sir Michael Franklin, KCB, CMG 1

MINUTES OF EVIDENCE TAKEN BEFORE THE COMMITTEE OF PUBLIC ACCOUNTS

WEDNESDAY, 20 NOVEMBER, 1985

Members present:

Mr R Sheldon, in the Chair

Mr E Cockeram
Mr E Deakins
Sir Peter Hordern
Mr M Latham
Mr R MacLennan
Mr W O'Brien
Mr G Park
Sir Michael Shaw

MR DAVID MYLAND, Deputy Comptroller and Auditor General, called in and examined.

Report by the Comptroller and Auditor General

ACHIEVEMENTS AND COSTS OF THE COMMON AGRICULTURAL POLICY IN THE UNITED KINGDOM (HC 578)

Examination of witnesses

SIR MICHAEL FRANKLIN, KCB, CMG, Permanent Secretary, Ministry of Agriculture, called in and examined.

MR C H A JUDD, Treasury Officer of Accounts and MR RICHARD BUTT, Assistant Secretary of Treasury, called in and examined.

Chairman

218. Welcome to the Committee this afternoon. We are considering the C&AG's report on the Achievements and Costs of the Common Agricultural Policy in the United Kingdom. We recognise that changes to the Common Agricultural Policy can only be proposed by the European Commission and approved by the Council of Ministers. This country is of course a substantial net contributor to Community funds and it is open to us to press for changes through the decision-making process. Our examination this afternoon is going to be particularly concerned with the role of your department in monitoring the effects of the CAP and advising where that policy needs to be reviewed or adjusted and in establishing as convincing a case as we can for any possible changes the United Kingdom wishes to make. Paragraph 6 of the C&AG's report on page 2 says that no Community document has sought to interpret the broad aims of the CAP into specific, quantified objectives. Does it not make it very difficult to produce purposeful measures and assess the effectiveness of them?

(Sir Michael Franklin) Could I say by way of introduction that I am extremely grateful to you for the recognition you made, and indeed the Comptroller and Auditor General did in the document itself, that we are dealing with a negotiating situation here. We are actually talking about how the UK operates within a negotiating framework in Brussels. The concern here is with the budgetary effect on the UK because even after the Fontainebleau mechanism we are still net contributors and therefore very much interested in the cost of the CAP as it comes through in terms of the cost to the Community budget. Also, of course, the wider resource cost of the CAP is very much in our minds. So far as paragraph 6 of the report is concerned, it is perfectly true that there is no single document you can point to. From time to time the Commission has attempted to give some kind of general steer to the Council of

[Chairman *Contd.*]

Ministers. So far as we are concerned I certainly would not like to give the Committee the impression that we are not interested in attempts to have more quantified measure of where we are going, where that is possible. The most notable example which came about as a result of a United Kingdom initiative is of course the financial guidelines within which the CAP now has to operate. That does set a parameter within which decisions have to be taken because of their financial consequences. Having said that I am bound to say that we ask ourselves whether having more specific quantified objectives would be helpful if, as a result of the negotiations to which I referred, we might end up with statements which were not actually the kind of statements we would ourselves have attempted to make. So there would be first the difficulty of achieving those kinds of statements and I am bound to say my own experience suggests that we could waste a great deal of time trying to get agreement on general statements which might be better spent on more specific objectives. Secondly, they might not be of the kind that we would find particularly helpful. To mention one of the first category: we did have a report from the Commission some time ago recommending that the Community should set as an objective a gradual approximation of Community cereal prices towards world price levels. We would have supported that and had we been able to achieve that as an objective in the Council of Ministers we would have regarded that as highly desirable; so far we have failed. As an example of the second kind: when we first joined the Community there was a so-called objective method which took a number of basic economic data and then said in effect that the results ought to show up whether or not farm incomes were increasing at the same rate as incomes elsewhere in the economy. When those figures were produced each year they tended to lend support to those members of the Community who were most concerned to maintain farm income and proved a considerable embarrassment to our negotiations and those of other member states who were more concerned with getting the balance of supply and demand better. In fact, gradually over the years, resort to that so-called objective method has fallen away. I am bound to say that since it has fallen away the record in terms of price increases has been rather better from our point of view. That would be an example where having a quantified objective would be positively unhelpful.

219. You realise of course that the Committee of Public Accounts normally works on the basis that without clear objectives there is no means of knowing how far any achievement is being attained. What you are saying is that there are cases where clear objectives are a positive disadvantage and fudged objectives superior in certain circumstances.

*(*Sir *Michael Franklin)* I am of course speaking of Community objectives and not of UK objectives.

220. I understand that qualification.

*(*Sir *Michael Franklin)* It is an important distinction.

221. We are all agreed that changes in certain instances since the Treaty of Rome in 1957 have suggested that the relevance and the adequacy of the CAP objectives do need some sort of review. What is MAFF doing to stimulate a review? Are you happy at letting certain sleeping dogs lie?

*(*Sir *Michael Franklin)* The objectives of the Common Agricultural Policy are of course set out in the Treaty and the report refers to Article 39 of the Treaty which sets those objectives out. There is currently an inter-governmental conference which is concerned with the whole question—going much more widely of course than agriculture—of whether or not amendments to the Treaty are desirable. I have to say that it has been the general policy of the Government to remain unconvinced about the need for changes in the treaty. We have therefore not been proposing amendments ourselves but have been ready to react to and to consider proposals from other member states. It so happens that no member state has proposed an amendment to Article 39 so we have not ourselves had to respond to that particular situation. I am bound to say that I am persuaded that if we had put forward an amendment or amendments to Article 39 of the Treaty of Rome in a sense which we might have written ourselves I suspect that would have provoked counter-amendments and I am not sure at the end of the day that we would have ended up with anything better. It is perhaps relevant to point out that when we joined the Community we examined Article 39 in relation to our then existing agricultural policies as enshrined in the 1947 Agriculture Act, found that they were very similar and did not in fact feel the need to repeal that particular part of the 1947 Act. So far as treaty amendments are

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concerned therefore no, I would not think that that would be frightfully helpful. It is of course true that some member states attach more importance to certain of the objectives than others. It is also true that since 1957 we have seen a shift in attitudes. It is quite clear that concern for the cost of the Common Agricultural Policy has grown throughout the Community in recent years and therefore the emphasis to be placed on some aspects of the objective would have changed over time; that of course is a development which we very much welcome.

222. What research or planning has the Commission or MAFF undertaken to bring about the argument for a switch in production to commodities for which there is a market or where smaller subsidies might be possible?

*(*Sir *Michael Franklin)* This has been very much a matter of public debate and indeed of concern inside the department as it has become clear that production on surplus commodities does need to be cut back. We have ourselves looked at the various possibilities and we have also commissioned a good deal of work on this whole area. I noticed for example that this very subject was in fact touched on by the Select Committee on Agriculture in its recent report on low input farming and the role of our advisory services. In the course of the discussion we did give the Committee a great deal of detailed information about the kind of work that we were doing. We have since then commissioned a special study at Cambridge university which is to be carried out by our former Chief Agricultural Officer into the whole question of the options which will be available for future land use as less can be used for the surplus product. A similar study on land utilisation changes is currently being done by the Agriculture EDC, of which of course we are members. I could perhaps mention some work commissioned by the Economic and Social Research Council from Reading university on future changes to British agriculture in the light of possible directions which the CAP might take. Those are a number of studies in which we are involved or have specifically commissioned. One of the areas everyone is interested in now is whether or not there is increased scope for woodland—growing more trees either on farms or in a more systematic way. We have put out quite recently a consultative document discussing how that might be encouraged.

223. The increases in Intervention Board spending have been shown in the Chancellor's Autumn Statement and they are disquieting because they confirm that the present price guarantee scheme is proving extremely expensive. Can you explain how the budgetary discipline which is referred to in paragraph 39 of the report is intended to operate in controlling the cost?

*(*Sir *Michael Franklin)* What happens is that the Finance Ministers set a parameter based on the resources base of the Community and from that is derived a figure which is of course not a target but a ceiling for total agricultural expenditure in the following year and that is expressed so that the increase in agricultural spending may not be greater than the increase in the own resources base. That then prompts first of all the Commission to put forward its proposals to the Council within the confines of that ceiling. It secondly requires the Commission on its own initiative or at the request of a member state to call for a special joint meeting of Finance and Agriculture Ministers if it looks as though the decisions are going to take expenditure outside that ceiling. It also requires the Commission in the course of the year to put forward proposals for economies if it appears that expenditure is going outside the ceiling. The budget which is currently being discussed in the European Parliament and the Council for 1986 has of course been drawn up against that particular requirement and is within, though I am bound to say only just within, those parameters.

224. Would you really call that budgetary discipline?

*(*Sir *Michael Franklin)* As compared with the situation previously when the Agriculture Council had, as it were, an open-ended budget this is a very significant development indeed.

225. Can I refer you to page 1, paragraph 4(e). This deals with one of the objectives of the CAP which was to ensure that supplies reach consumers at reasonable prices. Are there any criteria for this or have you given up?

*(*Sir *Michael Franklin)* The answer to the question is that there are no criteria but we certainly have not given up. It is true that the phrase "reasonable prices" is a general phrase but it does provide the basis on which we and other member states who share our concern are able to argue that in

[Chairman *Contd.*]

the decisions taken the interests of the consumer are given full weight. It has to be recognised that this is not an exact science and not everybody would attach the same weight to this particular objective as perhaps we have done over the years. But it is true to say, before one concludes that we have given up, that if you look at what has happened in terms of price decisions by the Council in real terms they have actually reduced support levels in every year since we joined the Community except two, 1974–75 and 1982–83 which was a rather exceptional decision anyway. It is also true, certainly in the UK and I think in all member states, with the possible exception of Greece, that we have seen food prices falling in real terms, certainly since 1979 when the UK retail food price index rose by 49 per cent compared with the whole RPI increase of 68 per cent. So one should not conclude that this objective has been lost sight of. Indeed when the Community, rather rarely as we would recognise now, gets into a situation of scarcity as it did in 1974 in the case of sugar and cereals, it can take action to protect food prices. What happened in 1974 when the Community had a very bad sugar harvest and world prices were going up very rapidly was that it first of all put a tax on exports and finally put a subsidy on imports of sugar in the Community from which we benefited to the extent of something over £40 million. Again in 1980 the same situation, though not so serious, arose and the Community put on an export levy to hold down the price inside the Community. These examples need to be taken into account in judging how effective that particular objective has been.

226. I am very concerned about objectives because sometimes objectives can be a bit muddled. Paragraph 46 gives an example of this on page 9. This suggests that the CAP guarantee measures fall between two stools. How can you get uniform price guarantees that regulate the market satisfactorily and at the same time give a fair return to every type of farmer? Is this not an impossibility? If it is an impossibility how can you get any objective that you can make use of?

*(*Sir *Michael Franklin)* It has to be recognised first of all that one is in the business of dealing with conflicting objectives. Any agricultural support policy has that kind of inherent problem. The question is whether you can reconcile a policy of prices in particular which would bring about a reasonable balance in the market and other objectives which would in the Community context be sought by us or other member states and notably an income policy. Could I just draw your attention to the fact that in paragraph 4(b) which is talking about standards of living and income there is an important little word "thus" which makes it clear there is no freestanding income objective as such in Article 39; it is an objective which derives from the success of the first of those objectives. So I have to say to you that the present price levels in the Community do not satisfactorily resolve that dilemma and are too high and probably have become too high because of the decisions in the Council of Ministers which have perhaps given undue weight to other considerations and so we have the present situation where surpluses have grown up and the cost has escalated.

227. Do you not see that there are distinct advantages in separating the measures so that you could regard one policy to stabilise the market and another to support poor farming communities for social reasons? Instead of having this muddied objective you separate them out and you approach them possibly in two different ways. How would your department view this idea?

*(*Sir *Michael Franklin)* On that we would be in agreement that one ought to see whether or not that kind of separation is cost effective. I say this because it might not always be so in a Community context. Certainly we would want to see price policy pursued in the Community with the principal objective of responding to the market and securing a better balance of supply and demand. I said earlier that we would not necessarily accept that there was a precise income commitment. Why I hesitate is that the thinking can easily move into an area—indeed what the Commission said in a recent document that if you are going to have lower prices then you must have income aids in order to sustain the income situation of certain classes of producers. That may or may not be true but I think, as indeed in paragraph 47 the Comptroller and Auditor General recognises, one would need to look at that kind of proposition very cautiously indeed. I am talking now always about the Community. If the Community were to accept an income aid commitment for the entire Community, bearing in mind that we have a farm size of roughly 70 hectares on average and the Greeks 4 hectares

[Chairman *Contd.*]

on average and the Community as a whole 16 hectares on average, we would be entering into a very expensive commitment indeed if we accepted that kind of income commitment for the entire Community. It would also be extremely difficult to devise such a scheme on a fair and equitable basis and one would need to be very sure that one was getting the *quid pro quo*. By this I mean that if you were to say we will recognise that you need to have an income support separated out and separately identified you would need to be very sure that you could guarantee that the prices, the market orientated prices, would actually stay down. Bitter experience suggests otherwise. If I may quote the milk quota situation, we introduced quotas in 1984 and the Council decided to increase milk prices this year. That is another example where you might not get your *quid pro quo*. We would not want to rule out *a priori* any examination of that kind of approach but we would be extremely sceptical about whether or not in an agricultural context as distinct from a general social context that would really be cost effective, particularly if it was financed by the Community. I am sorry that is a rather long reply but it is a rather important issue.

228. I understand that the Commission has recently produced a consultative document called "Perspectives for the CAP". How do your department intend to react?

(Sir *Michael Franklin*) It was put out in July as very much an options paper by the Commission and primarily with the intention of getting a widespread reaction not only from governments but also from farmers' organisations and so on. We have of course given some reactions to that document of a general kind. We welcomed in particular the main thrust of that document which was to recognise that current policies which were producing these surpluses could not go on and that it would be very valuable if we could, the Commission said, have a tough price policy maintained for a certain period. We very much welcomed that approach, as indeed their desire to have a more market-orientated policy. So our general reaction to the perspectives document was reasonably encouraging. The Commission are now in the process of collecting these various reactions and coming forward with more specific proposals because that was an options paper. We have already had such a document on cereals and we expect they will want to do that for other commodities. Our immediate attention is really on the more specific proposals of the Commission rather than the perspectives exercise which was really only to launch a debate. Its general thrust, however, was helpful.

Sir Michael Shaw

229. I must say that going over some of this ground does take me back a year or two. Probably things have changed a bit but it does not sound as though they have changed much. I fully understand that to alter the treaty is really not worthwhile attempting and I personally entirely agree with that; it leads to a lot of discussion and very little action. But if one moved along the lines of paragraph 46 and social payments and if one is seeking, as one is, to reduce prices to more realistic levels, if one did in fact try to have special payments for the small farmers—the Bavarian farmer is the one always mentioned but there are many others now—is there any way whereby it could be agreed that such payments would be national payments rather than Community payments? If one were to work on these lines there would be no need to alter the Community policy or objectives. On the other hand of course it would bring the prices down. Were that possible would that inhibit the inter-country sales because of the various subsidies that might be involved?

*(*Sir *Michael Franklin)* I did try to indicate earlier that I certainly would be much more cautious about a Community financed scheme, for the reasons that I gave, than some forms of income support nationally financed. But there of course you would, as you rightly say, need to watch first that they were production-neutral. That is very difficult to guarantee because if you put money in the chances are that production will actually increase. You would also have to watch distortion of competition, depending on how that was done. I am sure you would have to have some kind of rules but the Commission appear to be rather firmly of the view that anything of this sort should have some element of Community financing in it. That is where the cost benefit so far as the UK is concerned would begin to look much less attractive.

230. Would it be true to say the Commission continues to take that view and finds the support of most of the Community countries or are we seeking to change that view?

[Sir Michael Shaw *Contd.*]

*(*Sir *Michael Franklin)* There is quite a lot of resistance for different reasons to the idea of Community income aids, particularly from the northern member states who have the prospect of Spanish and Portuguese accession very much in mind. So there is no great enthusiasm for the income aids. Of course there is not as much enthusiasm as we would like for cutting prices. I can only repeat what I said earlier: we would be extremely fearful if we went down that road that we would not get the payoff in terms of lower prices.

231. Are we happy with our representation on management committees?

*(*Sir *Michael Franklin)* I certainly am. I do not know whether you have a particular case in mind? Obviously if there is a problem I should like to look into it. By and large we put a lot of effort into our representation on the management committees. They are a very important part of the daily business of running the CAP and explain why we have so many members of the Ministry of Agriculture going to and fro to Brussels. The figure was something like 2,000* visits by Ministry staff but it is very important and the management committees do take some rather important decisions. We certainly have very high calibre people attending them.

Sir Michael Shaw: I only asked the question because I realise their importance.

Mr Deakins

232. Does the Government still regard the objectives of the CAP in Article 39 of the Treaty of Rome as being valid or, in an ideal world—and we do not live in an ideal world—are there any changes that they would really like to see in those objectives and if so what are they?

*(*Sir *Michael Franklin)* When we came to join the Community we looked at the objectives of the CAP against our then ruling objectives, the 1947 Act, and concluded that they could stand together. It would be difficult to deny that the various elements in Article 39, as they are spelt out in paragraph 4 of the report, do not have some relevance to the conduct of agricultural policy. In other words it would be hard to argue that we should ignore any of those totally. The relative emphasis you place upon it would be very different so far as a British Government is concerned than perhaps some other governments. In short, we would not feel that the objectives as enshrined in the Treaty were unacceptable. We would place a different emphasis on the relative weight to be given to some of them than some of our partners in the Community.

233. It is of course not only the objectives which are important, it is the three basic principles of the Common Agricultural Policy which are not enshrined in the Treaty of Rome. The one I bear in mind particularly is common prices within common frontiers. Does Her Majesty's Government feel that those three principles, which have a much bigger impact as far as one can see on what actually happens in the Community than do the actual principles in Article 39, are sacrosanct or would HMG like to see changes in those?

*(*Sir *Michael Franklin)* One actually hears less about the sacred three principles in recent years than we used to some time ago. We certainly accept that if you are to have a support system some degree of Community preference is acceptable; we would argue about the degree. We do not question the financial solidarity but, as a result of the Fontainebleau mechanism, that operates in a very different and much more favourable way for the UK since that agreement was signed. This leaves us with the single market and we would attach great importance to that, primarily for reasons of general efficiency. If you have a single market you stimulate competition, you ensure that the more efficient producer has the best chance of taking that market and since we believe on the whole UK agriculture, because of its structure and technical excellence, is well placed in the competitive situation. Yes, we would think the unified market, which is after all one of the main principles of the Community as a whole, is a desirable thing. It is of course much complicated by the whole monetary compensatory amount system. We do not need to go into the complexities of it this afternoon and happily it plays a smaller part now as a result of the changes made in 1984. Yes, that principle is a very desirable one and one potentially of great benefit to the UK.

234. In paragraph 19 it is stated by the Ministry that it is not possible to show the effect of CAP measures because the only

Note by witness: This figure refers to *all* official visits overseas on European Community business, of which a high proportion would be for management committee meetings.

[Mr Deakins *Contd.*]

way you can show the effect is to show what might have happened had you had a different agricultural policy. I am not for one moment here disputing the truth or falsity of that particular proposition but one must deduce from it that the Ministry does not believe it is possible to show the effect of measures taken under the CAP.

*(*Sir *Michael Franklin)* It is important to make a distinction between measuring what I may call incremental changes and measuring an absolute. The distinction we were trying to make in the comment which appears in the report is that if you are going to say what is the effect of the CAP on food prices or on farm incomes or any other factor you then have to make assumptions about what the alternative is otherwise you have no measure against which to do that exercise. It has been done but it is only as strong as its assumptions and they may not be terribly helpful and meaningful. Certainly we do measure continuously the incremental changes. For example, each year there is a great price-fixing negotiation which is the biggest event in the agricultural calendar. We go into those negotiations with clear national objectives and we also make a continuing running assessment of the changes which might emerge as they would affect the various factors: cost, food prices, incomes and so on.

235. Would it be fair to say then that there is no means under the CAP of measuring the cost effectiveness of the policies?

*(*Sir *Michael Franklin)* I am not sure I understand what you would mean by the term "cost effective". We can measure certain things; we can measure the consequences in terms of cost; we can measure the effects in terms of what it has done to farm incomes and what it may have done to agricultural trade. There are obviously always imponderables about the effect on the environment which are difficult to measure. To be able to put those into one single equation is very difficult. You probably have to think in terms of a whole series of equations in which you relate one aspect to another aspect.

236. Then when the Ministry goes to the price-fixing in Brussels each year it does have some idea of the cost-effectiveness of previous measures and the possible cost-effectiveness of measures which it would like to introduce?

*(*Sir *Michael Franklin)* We start from where we are; we have the Commission's proposals which consist of price changes, and changes in the system; we will evaluate what we think those changes will be likely to do to retail prices, to farm incomes and then of course we establish some kind of order of priority in the terms of our negotiations. We establish our domestic UK objectives on the basis of that kind of evaluation.

237. Would it be true to say that at the price fixing the UK has its own national objectives, and there we have some control because we know what we want—we may not get it but at least we have a good idea and we have the statistics. But earlier you implied, in fact you almost stated, that at EEC level fudged objectives were better than very clear objectives. I do not wish to dissent or assent to that particular proposition but if in fact fudged objectives are considered best is there not an economic cost for the UK in the sense that we are not merely paying for the achievement or otherwise of our own objectives but we are paying the cost very heavily of the achievement or otherwise of fudged or clear objectives of the Common Agricultural Policy as a whole so we do have an economic interest in trying to ensure that the CAP does have clear objectives rather than fudged objectives otherwise we are just paying the bill and the more fudged objectives are the less control we have over the final bill.

*(*Sir *Michael Franklin)* It is not so much fudged objectives as having different objectives and each member state goes into the negotiation with a different set of objectives. As the report itself rightly brings out, one of the values of having a package settlement, which is how these things usually emerge, is that each member state can get out of that particular negotiation what it regards as the most important. Unless you wish to say we are particularly bad negotiators you cannot conclude that that process will operate to the net disadvantage of the United Kingdom. The point you are making really turns in the end on how successful we are in the negotiations.

238. On the issue of a possible move away from general support to specific income support plus agricultural price support at much lower levels you did say you thought that would probably not be to the UK's advantage because there are so many small farmers. One understands that in the EEC. If they all had some sort of income support they would be getting more money than they are getting now and we would not

[Mr Deakins *Contd.*]

necessarily save that extra amount of money by price reductions. Does that really mean then that you are implying there is no prospect ever of getting effective price reductions as part of a bargaining process within the Community?

(Sir Michael Franklin) No, not at all. One has to recognise from experience that it is not easy to get prices down in the Community but we did manage to get reductions in the 1984 price fixing in nominal terms and we eventually came out with small reductions in cereal prices this year inspite of the enormous struggle we had with the Germans. In real terms of course they represent a bigger fall. I am not saying that the reductions are big enough but I certainly would not think in any way we should give up our effort to do it. What I was really saying was that we need to be cautious about accepting the notion that we can only succeed if we are prepared to underwrite very expensive forms of Community income aids. That is the conclusion I am wanting to guard against.

239. In the annual price fixing the Ministry obviously goes in with some idea of what it wants, preferably some sort of price reductions for the major commodities in surplus. Does it also have in mind, in negotiating those price reductions with its partners in the Community, that it is not actually always negotiating the prices which are going to be received by farmers in different countries? I am not thinking now about MCAs but whether it is the green rate or the representatives rate—I cannot remember which but to do with currency changes. There was a case last year where reductions were negotiated for cereals or milk products—a major item—but by the time currency changes had been taken into effect a country like France actually had an increase and several other countries had increases in the prices actually paid to their farmers within the context of a decision by the council of Ministers of an overall reduction. Surely that not merely complicates matters but undermines the whole basis on which the Council of Ministers are taking decisions?

(Sir Michael Franklin) The example you quote was not something nobody knew about. It is all part of the MCA system and it has been customary to negotiate changes in the green rates at the same time as you negotiate changes in the institutional prices. It is perfectly true that those countries who had and still have negative MCAs are able, if the Council agrees to a change in the green rate, to get an increase in national currency terms, or at least to mitigate the effect of the change in institutional prices. That of course is because they are countries with high rates of inflation. In so far as, generally speaking, high rates of inflation and weak currencies go together that has been the case, for example, for Italy and Greece, who have had rather large negative MCAs. So if you look at the actual outcome in terms of real price changes what I said earlier about them being on average reductions in almost all the years except two is still true. So that aspect of the negotiation is part and parcel of the whole package. Happily we have not had such big currency fluctuations against the ECU in the last few months and as a result of the system which was agreed in 1984 there are much smaller positive MCAs than there were before. Currently—I think I am right—we do not have very large negative MCAs except for Greece.

240. Two last points: one is on the budget discipline agreement stemming from the Economic Ministers. It puzzled me and it would be helpful if you could explain. The budget discipline agreement, like the Community budget itself, applies to the calendar year, the fiscal year. However the agricultural marketing years for various crops go from June to June, August to August and so on. Surely what you are therefore faced with is the situation, with the best will in the world where the budget discipline says that in 1986 the total cost of the CAP should not go up by more than X per cent but during 1986 you have agricultural prices for the first part of the year fixed previously and then you have a new set of agricultural prices for the six or seven months of the rest of 1986. How in all conscience is it possible to operate a budget discipline over agriculture when you are talking about different years?

(Sir Michael Franklin) It is perfectly true that the agricultural years vary from commodity to commodity, therefore you cannot have a single agricultural year. If you had a single agricultural year there might be a case for making that coincide with the budget year but you cannot do that. The problem to which you refer is solved because when the Commission makes its proposals it will identify the effect of those proposals on more than one budget year. Take the example of the forthcoming price fixing. The Commission will make its

[Mr Deakins *Contd.*]

price proposals and it will say what impact that will have on the 1986 budget, which is likely to be relatively small, and more importantly on the 1987 budget. So you can always attribute it to one or other calendar year and obviously there are estimating errors in that but that is how you then relate it to the budget guidelines on a calendar year basis.

241. Your Minister attends the Council of Ministers not merely as the Minister of Agriculture but as the Minister for Food. He therefore has, one hopes, a consumer interest to put forward. Can you say how many of the other member states have Ministers of Agriculture who are also responsible for consumer prices and to the extent that they are not responsible for consumer prices, does it not add to the bias in the price fixing in favour of the farming community, rightly or wrongly and against the consumer, except in the case of our own country perhaps?

*(*Sir *Michael Franklin)* I cannot give you the precise designation of all the Ministers who sit round the Agriculture Council but each of them of couse is speaking to a government brief. The decisions of the Agriculture Council are the decisions of the member states each taking their own government position. One assumes, indeed it is certainly the case on the agricultural price fixing, that all Ministers whether they are Agriculture and Food or just Agriculture, are mandated by their respective governments. I am afraid I do not know exactly the answer to your question.

Mr Cockeram

242. Can we take our mind back to the essentials where we started. In the case of some essential food commodity, if there were to be, say, a 10 per cent shortage, is it not the case that 10 per cent of consumers by definition would go without supply and since market forces apply in the pricing mechanism the other 90 per cent pay a higher price? So in that respect, in one way or another, all consumers lose. Whereas, if there were to be in that same essential commodity a 10 per cent surplus, is it not the case, since market forces apply on price, all consumers tend to get the commodity at a more competitive price and the only problem is handling the surplus?

*(*Sir *Michael Franklin)* What you enunciated are some basic laws which are not peculiar to agriculture, they would apply to shirts or suits or anything else. There is a widely held belief which we do not share that agriculture does not respond in supply terms in the way that most sectors of the economy do; we believe that fundamentally it does, that is to say if you have a price reduction you will get a supply response in a downward direction and vice-versa . . . It is perfectly true of course that there is a single price, all producers get it and the result of that is that the least efficient producer at the margin is the one who will be affected if you reduce the price or increase it, as the case may be. That is not a particularly bad way to do business.

243. My question never mentioned producers, it mentioned consumers. Do you agree with my question or disagree with it?

*(*Sir *Michael Franklin)* I agree with it.

244. Can we go on to follow that through since in most essential commodities we are facing the problem more frequently of surplus than deficiency of production. Is the next problem therefore not to endeavour to ensure that the restriction on production applies more severely to the large producer—I put in brackets the word "efficient" just on logics of scale—and to seek to protect the small—I am not going to use the word inefficient but higher cost—producer in view of the social objectives? Is that not the case?

*(*Sir *Michael Franklin)* This is where I would perhaps begin to part company with you. It seems to me that price has its primary function in terms of equating supply and demand. In an over supply situation the consumer ought to benefit, other things being equal, from lower prices. If you wish to draw a distinction for social or any other reasons between large or small I do not think you can, or indeed should, do it through the price mechanism but I did try in my earlier intervention to warn against embracing what I think is your suggestion on a Community basis because we might then find ourselves saddled with some extremely expensive schemes.

245. Is it essential to do it on a Community basis? For example, the problem exists of surplus milk. We have within the UK sought to solve that problem by having the extra quota cut of 2.5 per cent and seeking to protect the small producer, which in the UK we define as someone with less than 40 head of cattle. That is an example of seeking to protect the small producer compared with the large producer within the UK. That has no reflection on the conti-

[Mr Cockeram *Contd.*]

nent. Is that not a desirable objective?

(Sir Michael Franklin) The first point of course is that we did not ourselves advocate the solution to the milk surplus through quotas. We would have gone for a price solution. Once you have a quota situation then of course everybody is cut back, the efficient with the least efficient, and that is one of the objections to a quota system. Having got a quota system you are then free to play with it in the way that we have done in the UK deliberately in order to create a small reserve and then to reallocate it with preferential treatment to milk producers with below 40 cows. That is a deliberate decision of Government: we were free to do it and we did it. The danger we have to watch is that kind of rule being applied on a Community-wide basis and, as it were, encouraging people. The latest proposal, for example, of the Commission on cereals, is to have a co-responsibility levy but to exempt a certain number of producers, or indeed the latest proposal on milk quotas which is to enable 3 per cent of quota to be bought up but to allow member states to exclude all milk producers who have five cows. As we know, there are not many milk producers in this country with only five cows; there are a great many in Italy and Greece and Germany. Exceptions of that sort applied on a Community basis are almost invariably going to operate to the UK's disadvantage, which is why from my point of view, negotiating on behalf of the United Kingdom in the Community, I have to be very careful indeed of these kinds of exceptions applied on a Community basis. In so far as the Community rules leave you free to take your own internal decisions of course you are free to do what we have done in the case of milk.

246. I accept the point you make about the problem of small producers on the continent; I accept it and am not seeking to pursue that point. I am seeking to pursue the point within the UK and I have quoted the small milk herd of under 40 head of cattle as an example. Is it not the case or is it your objective to endeavour to protect the small producer of other commodities in the manner in which you have done successfully with milk production so that any cut that may come is biased in favour of seeking to maintain the income of the small producer within the UK rather than an across-the-board cut which naturally must favour the large producer? If so, what thinking and steps are you taking on these lines?

(Sir Michael Franklin) I cannot give you a straight answer to that question because you are really asking me what the Government policy would be in a rather hypothetical situation where we did, as we do in milk, have ability to adjust the terms under which small or large producers trade. That is a rather hypothetical question and I cannot answer it. The Government would have to make up its mind. Let me take the cereal situation: if we were regrettably ever to have any kind of quantitative control over cereals then that possibility will be opened up and it will be for the Government then to decide whether it wished to use it in the way you suggest or not, but it is a hypothetical question.

Mr Maclennan

247. The report of the Comptroller and Auditor General at paragraph 40 quite nicely expresses the balance of successes and failures of the CAP and in the last sentence summarises the failure: surplus production, cost of storage etc. Back at paragraph 22 the further defects of the existing system of price support, from the point of view of producers, is drawn attention to. Why do you continue to emphasise price restraint as the desirable means of eliminating these deficiencies or defects of the policy when so clearly it has not worked in the past, surpluses have continued to be piled up and when it does not achieve the income objectives that one might wish to see in that it over-compensates the large producers and it under-compensates, or at least leaves the smaller producers with a less than adequate income. What experience is there of price restraint which encourages one to believe that that is a sensible policy to be pursuing?

(Sir Michael Franklin) If you were to look at the late 1960s when the Community had a price freeze for three years you will find that milk production actually went down in that period. If you want past experience that would be the one I would like to quote. You say that it has not worked and I have to say that it has not worked because it has not actually been tried. Can I perhaps give you some figures on wheat where we have had a burgeoning surplus. If you look at what has happened over the last four or five price fixings: we put the price of wheat up in nominal terms by 28 per cent. Of course you have had inflation over that period and in fact that has meant for the Community as a whole a fall in real terms of 12 per cent over that same period. Equally over the same

[Mr Maclennan *Contd.*]

period you have had a productivity growth in terms of high yield of wheat of 29 per cent. The result of those figures is that real return per hectare—and that of course is what matters to the farmer—has actually gone up by 14 per cent. It is hardly surprising that cereal production over that period has increased. I would venture to suggest that had we been cutting the price in real terms per hectare over the same period you would have seen fewer cereals produced in the Community than has in fact been the case. It is not true to say that the policy has been tried and failed; it has been found difficult and not effectively tried. You may have a view that we were not very successful this year in getting down the price of cereals because of the attitude particularly of the German delegation. That is no reason for not putting that very high on our list of priorities. It appears to be high on the list of priorities in the Commission too. Indeed, even in Germany though they would not be happy to see reductions in nominal prices they are sufficiently realistic to recognise that they are not going to get price increases.

248. You dismissed Mr Cockeram's suggestions as hypothetical because they were not Government policy at the present time, but what you have just put forward by way of explanation of what has happened is also rather hypothetical: wouldn't it have been nice if something else had happened? But it did not and the fact is that we have seen the kind of increases that you have just described going ahead, notwithstanding the policy of the British Government year in and year out in seeking price restraints. How long is the British Government going to go on pursuing a policy which has produced such results? Is it not one of the great weaknesses of this policy that any form of price support under the present system is open-ended? If you put pressure upon the price you are actually offering an inducement to increase the output.

*(*Sir *Michael Franklin)* My answer to Mr Cockeram was to an entirely different question: whether you want to manipulate policies in favour of small or large producers.

249. You dismissed it in general because it was hypothetical but what has happened in the past is not hypothetical, it is quite concrete.

*(*Sir *Michael Franklin)* What we are discussing here is whether or not it is right for the British Government to have a policy on price restraint. What I was trying to suggest was that I do not think anybody has got any evidence to say it would not work if it were applied. On the contrary I think it would work. All the studies which have been carried out will suggest that if prices go down supply will be lower than otherwise; certainly consumption will respond, which people tend to forget when they advocate non-price solutions——

250. That is the theoretical position and I have no doubt it is theoretically justifiable but we have got to look at the record, the history. What sort of price reduction would be necessary now to reduce the cereal prices which you have so graphically described to the committee to a level at which supply and demand would be broadly in balance—slightly more supply than demand in order to deal with possible weather shortages? What sort of percentage reduction in institutional prices are you talking about?

*(*Sir *Michael Franklin)* The Commission have estimated that you would need to reduce prices of cereals by 20 per cent in order to establish a balance of supply and demand.

251. What was the percentage that the Germans jibbed at last summer?

*(*Sir *Michael Franklin)* Three point six.

252. Why are we then talking about 20 per cent if we cannot get three point six? Is it not patently nonsense?

*(*Sir *Michael Franklin)* It is a slightly *ad terrorem* argument to say that because you have got to cut prices by 20 per cent to achieve perfect market balance, you might as well give up the attempt to reduce prices at all. If I could remind you what happened in the case of the milk quotas: it was clear that, and the Commission said at the time, you would need to cut the milk price by 12 per cent in order to establish a balance. That was considered to be politically unacceptable so we introduced quotas. However, we did not introduce quotas which broughtthe production of milk in the Community back to an equilibrium level, we reduced the milk production by roughly 4 per cent and left ourselves with a surplus of 13 per cent. So, if I may venture to suggest it, you do need to compare like with like.

253. I should very much like to compare like with like. The options which are spelt out here to deal with the income problem are to separate income support and price

[Mr Maclennan *Contd.*]

support but there is another option and that is the one you have been talking about both to Mr Cockeram and myself: the question of quantitative support which you indicate the Government was quite unprepared to contemplate until the last minute and it was virtually forced on it in the price fixing. Are you doing any contingent planning for a similar eventuality in respect of other commodities for which there are other considerable problems?

*(*Sir *Michael Franklin)* Yes, we are obviously looking at all the possible options including quotas, even though we do think they are likely to have major disadvantages for the Community as a whole and for the UK in particular. I have to say in the particular case of cereals, which is clearly the most immediate issue, there is no evidence that the Commission is going to propose a quota solution on cereals.

254. In the short term; but this is a long term problem. It is not going to go away in the next price fixing, is it?

*(*Sir *Michael Franklin)* I very much hope that we shall make a major attack on the cereal problem in the next price fixing but I cannot obviously say to the Committee this evening exactly what the outcome of that negotiation will be.

255. Is not the theoretical attraction of quotas at least this that it could be used to tackle the problem enunciated by the Comp-troller and Auditor General at paragraph 22 of the over-recompensing of the efficient producers and under-recompensing of the smaller producers?

*(*Sir *Michael Franklin)* Nobody says that you are over-recompensing the efficient producer of motorcars because he makes a higher profit than the chap who is producing at the margin, so I personally would not use that term. The report of the Comptroller and Auditor General, in so far as it pointed us in one direction did point us in the direction of paragraph 47 which is the sort of income support idea and I did try to explain earlier why I certainly do not rule it out although there are considerable dangers. There are obvious advantages in the quota option: it operates quickly, you can control it, but there are very serious disadvantages. It tends to freeze the pattern of production.

256. It need not do so if the quotas are tradeable.

*(*Sir *Michael Franklin)* Up to now we have not succeeded in the Community in getting that element into the milk quota system.

257. Has the Government tried?

*(*Sir *Michael Franklin)* Yes. There are obvious advantages to quotas, you can see that, but it is important also to see the other side where, if you cannot have them transferable you tend to freeze the pattern of production. You certainly do nothing to encourage consumption through a quota system and you do nothing to improve consumption as compared with a policy of reducing the price; that must be true. You do introduce an administrative system and that opens the way certainly to the kind of differentiated policy which Mr Cockeram referred to, both here and elsewhere in the Community, but it also opens the way to different degrees of administration and one of our worries undoubtedly with a quota system would be how efficiently it would be operated in other member states.

Sir Peter Hordern

258. Did I hear you say that there was really no great difference between the efficient and substantial producer of cereals and the efficient and substantial producer of motorcars?

*(*Sir *Michael Franklin)* No; one is supported and one is not.

259. Precisely. I think you said earlier in your remarks that the United Kingdom made a clear national assessment of its position before you entered negotiations with the Community. I assume from that that you do follow a clear national policy in order to seek the best advantage for the United Kingdom in those negotiations. Is that correct?

*(*Sir *Michael Franklin)* Yes.

260. Then may we turn to page 11 of the C&AG's report where we find that we make, bar Germany, the largest single proportional contribution to the budget and yet receive almost the lowest payment from the Community. At any rate the distinction between the two is the most substantial. Do you think we do very well in pursuing our national objectives?

*(*Sir *Michael Franklin)* You could not draw a conclusion one way or the other from reading Table 1 on page 11, which of course is primarily a function of how important agriculture is in the national economy and the size of GDP in the Federal Repubic of Germany and the UK. What is obviously important, and I said it right

[Sir Peter Hordern *Contd.*]

at the outset, is that one of our objectives, because even after the Fontainebleau mechanism we still remain a net contributor, is to try to ensure that that net contribution is kept to a minimum.

261. Let us take one particular commodity by way of example. Let us take cereals. Table 3 on page 13 shows that the cost of intervention and private storage for cereals next to beef is the largest in the European Community and that our particular share in the United Kingdom is the largest of all. How many cereal farmers have we in this country?

*(*Sir *Michael Franklin)* Nearly 100,000.

262. What is the case for supporting cereal farming in this country?

*(*Sir *Michael Franklin)* As distinct from the rest of the Community?

263. No, as compared with other products such as dairy products.

*(*Sir *Michael Franklin)* The CAP is a policy of supporting agriculture and all its main commodities of which cereals and milk are two very important ones.

264. I have noticed, as you must do better than anybody, the way in which these negotiations have been conducted and the way in which West Germany has managed to obstruct—if that is not too strong a word for it—any substantial reduction in cereal prices because West Germany thought it was in their national interest to do so. Milk producers have had quotas imposed upon them which at the time seemed to strike rather hard. How can you say that our national interest has been properly advanced when we are contributing so substantially in the costs of intervention storage and not least in disposal costs—very substantial sums there—whereas West Germany appears to have got its way? Why did you not get your way?

*(*Sir *Michael Franklin)* Let me take you back to the milk quotas. We had as an objective to do something about the milk surplus because we thought that was unacceptable on economic grounds and of course it was very expensive and we were paying for it. It became clear in the course of negotiations that the only way to get agreement on some effective decision to restrict milk production was on the basis of quotas so we went along with the quotas and the quotas were allocated between member states in a way that the reduction for the Community as a whole was approximately four per cent. The cutback in the UK was higher than this average but lower than in several Member States including Germany. I do not know whether you regard us as having got our way on milk or the Germans having got their way but there was a decision taken in 1984 which actually began to deal with the milk surplus.

265. The truth is that there is a substantial number of dairy farmers in this country and a number of small producers; there are far fewer cereal producers and a number of them by any criterion are very wealthy people indeed. What is the basis upon which you can defend supporting some of the richest people in this country with money produced by the taxpayer?

*(*Sir *Michael Franklin)* I am not wishing to defend the present situation on cereals policy.

266. What are you doing about it?

*(*Sir *Michael Franklin)* I said we had a proposal from the Commission now which we are just beginning to discuss among the member states. It is a proposal which I would characterise as timid and that is to say it does not go far enough and fast enough to deal with the cereal surplus. We shall be doing our best in the weeks ahead to find a solution which is as effective as possible. We have to negotiate of course on the basis of what the Commission proposed. That is how the Community works.

267. I do not know that it works entirely like that because the results of the negotiations do not always, or even often, coincide with the proposals of the Commission. Be that as it may what proposals are you going to put before the European Commission which will have some real effect on reducing the substantial and obnoxious surplus in cereals which is costing the Community so much money and for which there is no evident reason whatever so far as this country is concerned?

*(*Sir *Michael Franklin)* The Minister made the position clear in the Council earlier this week when there was a first discussion on this Commission paper, that he did not consider the Commission's proposals adequate in terms of their definition of the price policy which needed to be pursued on cereals. We do have some difficulty with the Commission's proposals for a co-responsibility levy since we do not think that is the most effective way of tackling the problem; we prefer to tackle it more

[Sir Peter Hordern *Contd.*]

directly. The other element in the Commission's proposals deals with the intervention system and we are prepared to look at that in a way which would be helpful from the point of view of what you are saying, that is to say weaken the intervention system and thus give less support to the cereal sector.

268. Has it ever been considered in the Treasury that in order to provide an incentive to the Ministry of Agriculture in their negotiations in the European Community the Vote for the Ministry should be scaled down a substantial amount in order to provide a proper incentive for them to stop producing extraordinary and unwanted amounts of money for the costs of cereal intervention and support?

*(*Mr *Judd)* It is very unlikely that any such arbitrary basis of allocating the Ministry its money has ever been considered, no.

269. What effort is the Treasury making to try to bring the Ministry of Agriculture to the position where it may take proper steps to see that the cost of subsidies in wheat and cereal intervention are not so large as they are at present?

*(*Mr *Judd)* The Treasury cannot accept the premise of the question that you are putting.

270. What precise proposals is the Ministry going to put forward to reduce the cost of cereal subsidies?

*(*Sir *Michael Franklin)* My answer to that question was that we will not put forward proposals we will react to the Commission's proposals in the way that I just described. Would you just allow me to add to the earlier discussion in which you were very critical of the fact that we failed to get our way on cereals this year. The Committee does have to recognise that the German Government felt so strongly about cereal prices that it decided for the first time ever to invoke the Luxembourg compromise, that is to say they were not prepared to be outvoted. It is the policy of Her Majesty's Government to support that particular position; although we wish to see greater use of majority voting we do respect that right and therefore we acquiesced in the use of the veto in that situation.

271. So if it had not been for the Luxembourg principle may I take it that the Ministry would have insisted that the price of subsidies for cereals be substantially reduced?

*(*Sir *Michael Franklin)* We argued for a five per cent cut in the price of cereals this year. It is worth bearing in mind that we did agree in the Council in 1981 a guaranteed threshold for cereals under which there would have been an automatic cut in prices if production exceeded the guaranteed threshold. The price of cereals should have been cut by 5 per cent this year and we supported that position.

272. Was it not the case that the Minister suggested that an appropriate reduction would be eight per cent not five per cent, on the floor of the House?

*(*Sir *Michael Franklin)* The guarantee threshold mechanism had a cutoff of five per cent. In other words you related the production to your base threshold and by simply comparing those two you would have had on the one per cent for every million tonnes an eight per cent cut but the mechanism had a cutoff of five per cent. So what we actually said was that we thought—I cannot remember the precise wording—the mechanism should be allowed to apply in full as compared with the Commission's initial proposal which was a cut of 3.6 per cent.

Mr Park

273. All afternoon we have been in the unusual difficulty in this Committee, and you are not excluded, because we keep bumping up against policy considerations. You will be aware that this Committee normally steers well clear of policy; that is one difficulty. The other difficulty is the one which the C&AG came up against and which is fairly well highlighted in paragraphs 43 and 44 on page 9 where he says, "It is difficult to design a cost-effective financial support system unless the objectives . . . embody criteria against which their achievement can be measured." Because of that you have found yourself in difficulty trying to answer some of my colleagues' questions. But I find it difficult to accept the next paragraph where it says that your department, or maybe it is all the agriculture departments, "took the view that a more precise definition . . . would not assist the UK in negotiations or in its attempts to reform the CAP" and, ". . . it would be unrealistic to expect EC Ministers to commit themselves to forward targets". Why would it be unrealistic for our Ministers—I know you said that we go into these interminable negotiations with a national assess-

[Mr Park *Contd.*]

ment of the situation, so surely that is a target?

(Sir *Michael Franklin*) I am not sure that it is a target in the sense in which that term is sometimes used; it is certainly an objective and you are putting your finger on the difficulty of distinguishing between national UK objectives on the one hand and what paragraph 43 was primarily concerned with, which is the question whether or not it actually makes sense to apply the limited amount of negotiating capital we all have to try to get 10—and as from the beginning of next year 12—Ministers to subscribe to what will inevitably be a form of words which might or might not assist you in the actual negotiation on prices and support mechanisms. That is the problem.

274. But you took exception to Mr Deakins when he suggested that this was a fudge—in my view one almighty fudge. You said no, they are different objectives and they may conflict. A rose by any name, it is still a fudge and it suits some sections of the farming community very well to have it continue to be fudged because there is absolutely no reason in the world, just going from the figures we have here, that people producing grain should be subsidised at all. Mr Judd said he could not really comment. I may have got this all wrong but my understanding always was that at a certain time of year all the Secretaries of State are gathered together and they fight tooth and nail for their department and their budgets are the subject of fairly close scrutiny and there are even rows between the Secretaries of State. What is different about the Ministry of Agriculture that they can get away with murder?

(Mr *Judd*) It is not my conception that Ministers get together and fight tooth and nail in quite the way you are implying.

275. You wriggled out from under when Sir Peter put it to you. Does the Treasury make any comment about this? Does it say: come on you are not getting that amount this year? They would put it more politely than I do but surely they say something like that?

(Mr *Judd*) Of course the Treasury takes a very considerable part in the negotiations with other Ministers about the allocation of resources for the year to come, certainly, yes.

(Mr *Butt*) We have very serious and thorough discussions with the Ministry of Agriculture and the other three agriculture departments on their expenditure every year. But one does have to distinguish between the domestic expenditure programmes which are to a large extent within the control of Agriculture Ministers and where one gets rather closer to the position where a Treasury Minister can say he really must insist on a five or 10 per cent cut and expenditure which flows directly from Community decisions where the Treasury Minister can only exhort his agriculture colleagues to bring influence to bear in Brussels to achieve these objectives. The subject of this afternoon's discussion has been that second situation where we in the Treasury have to recognise that the Minister of Agriculture and his colleagues cannot themselves directly deliver particular expenditure targets on the Community front but have to negotiate them through the Community. The final point, having said all that, is that the Chancellor of the Exchequer was directly involved in the negotiations on budget discipline which produced a financial guideline for agricultural expenditure and in that sense he has taken part directly in the Community in trying to set a limit. But that is the nearest a Treasury Minister has been able to come to the situation Sir Peter obviously thinks would be desirable and that is about as close as one can get.

276. He did not seem to come down as hard on the Minister of Agriculture as he did on the Minister for Housing. This is the comparison I am drawing. The Minister of Agriculture seemed to enjoy a privileged position.

(Mr *Butt*) In last year's public expenditure survey— not the one which has just been completed—there were substantial cuts in the domestic expenditure at the Ministry of Agriculture of over £100 million in a full year. The Ministry of Agriculture and their colleagues did not feel they got off lightly in that survey; they did not get off lightly this year either, in so far as expenditure which they control is concerned.

277. A little while ago I was at the Volkswagen car factory and it was getting near to knocking off time and the chap who was showing me around said that immediately the bell goes the men will be through the gate like a greyhound at White City. I said it was fair enough that they were sick and tired of putting cars together but why? He replied that they had all got smallholdings. I probed it a bit further and found that

[Mr Park *Contd.*]

practically every one of them was drawing subsidies. I do not object to anyone having a secondary source of income if they want to work hard for it; fair enough. But I see absolutely no reason why the UK should be being taken to the cleaners. Judging from your answers this afternoon, Sir Michael, I cannot avoid the conclusion that we are going to continue to be taken to the cleaners.

(Sir *Michael Franklin*) I do have a figure confirming the fact that in the Federal Republic of Germany there is an enormous number of part-time farmers. Almost half German farmers spend less than 50 per cent of their time on the farm and of these three quarters have a gainful outside activity. I entirely agree with you that if one were talking about income aids you need to think very carefully about what you are aiding and you need to take account of these non-agricultural sources of income. If a part-time farmer has an adequate source of income elsewhere then the need to think of supplementing his agricultural income is clearly much less. This is another factor to be taken into account when one is thinking of possible income aids.

Mr Maclennan

278. I wanted to pursue a little the question of the Treasury's role in the price fixing. I quite understand the point Mr Butt made about the need for Ministers of Agriculture to have negotiating room when they are coming to an agreement in the price fixing but does the Treasury agree any parameters before these doughty Ministers depart to fight their corner?

(Mr *Butt*) This is a question which Sir Michael can answer as well as I can. The answer is that the brief which the Minister of Agriculture has at any Agriculture Council, but particularly in the price fixing, is one which is agreed inter-departmentally. So Treasury Ministers and other Ministers as well will have been involved in the formulation of the general policy objectives and to a considerable extent in the details as well in the case of the annual price fixing. So that answer is yes, but it is not just a matter for the Chancellor it is a matter for Ministers collectively.

279. The Chancellor or the Treasury Ministers could say—I do not know whether they do say—thus far you may go but no further and you will need to come back to your colleagues for dispensation if you go above the limits. Is that a fair representation?

(Sir *Michael Franklin*) That certainly happens.

280. Does that ever happen in practice?

(Sir *Michael Franklin*) Yes.

281. Negotiations have been broken off and Ministers of Agriculture have to say they cannot agree to them without further consultation?

(Sir *Michael Franklin*) Yes, that happens.

282. Is it the case then that the settlement, when it comes, comes with the Treasury's blessing?

(Sir *Michael Franklin*) Acceptance.

Chairman: Thank you for coming to answer our questions today.

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HOUSE OF COMMONS

Third Report from the

SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

Volume I
Report together with the Proceedings of the Committee

Ordered by The House of Commons *to be printed*
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72–I

The Social Services Committee is appointed under SO No 99 to examine the expenditure, administration and policy of the Department of Health and Social Security, associated public bodies, and similar matters within the responsibilities of the Secretary of State for Northern Ireland.

The Committee consists of a maximum of eleven members, of whom the quorum is three.

The Committee shall have power—

(a) to send for persons, papers and records, to sit notwithstanding any adjournment of the House, to adjourn from place to place, and to report from time to time;

(b) to appoint persons with technical knowledge either to supply information which is not readily available or to elucidate matters of complexity within the Committee's order of reference;

(c) to communicate to any other such committee its evidence and any other documents relating to matters of common interest; and

(d) to meet concurrently with any other such committee for the purposes of deliberating, taking evidence, or considering draft reports.

Unless the House otherwise orders, all Members nominated to the Committee continue to be members of the Committee for the remainder of the Parliament.

WEDNESDAY 14 DECEMBER 1983

The following were nominated as members of the Committee:

Mr James Couchman
Mr David Crouch
Mrs Edwina Currie
Mr Roy Galley
Mr Ron Lewis
Mr Tony Lloyd
Mr Michael Meadowcroft
Sir David Price
Mrs Renée Short
Rev Martin Smyth
Mr Nicholas Winterton

Mrs Renée Short was elected Chairman on Tuesday 20 December 1983

The cost of preparing the shorthand minutes of Evidence taken before the Committee and published with this Report was £3726.82.

The cost of printing and publishing this Report is estimated by Her Majesty's Stationery Office at £6,480.

Changes in Committee membership:

Session 1984–85

Friday 16 November 1984

Mr David Crouch *discharged.* Mr Steve Norris *added.*

Thursday 18 April 1985

Mr James Couchman and Mr Tony Lloyd *discharged.* Mr Tony Favell and Mr Terry Patchett *added.*

Session 1985–86

Friday 6 December 1985

Mr Steve Norris and Mr Michael Meadowcroft *discharged.* Mr Charles Kennedy and Mr Tim Yeo *added.*

Tuesday 17 December 1985

Rev Martin Smyth *resigned.*

Tuesday 8 April 1986

Mrs Edwina Currie *discharged.* Mr John Powley *added.*

LIST OF ABBREVIATIONS USED IN THE REPORT

ACOP	Association of Chief Officers of Probation
AIDS	Acquired Immune Deficiency Syndrome
AMBOV	Association of Members of Boards of Visitors
BMA	British Medical Association
BMJ	British Medical Journal
BPA	British Paediatric Association
DHA	District Health Authority
DHSS	Department of Health and Social Security
DPMS	Directorate of Prison Medical Services
FPC	Family Practitioner Committee
GP	General Practitioner
HAS	Health Advisory Service
IPCS	Institution of Professional Civil Servants
MHA	Mental Health Act
MIND	National Assocation of Mental Health
NAPO	National Association of Probation Officers
NCCL	National Council for Civil Liberties
NHS	National Health Service
PMA	Prison Medical Association
PMS	Prison Medical Service
POA	Prison Officers Association
PROP	National Prisoners' Movement
PRT	Prison Reform Trust
RAP	Radical Alternatives to Prison
RCGP	Royal College of General Practitioners
RCPsych	Royal College of Psychiatrists
RHA	Regional Health Authority
SCPS	Society of Civil and Public Servants
WIP	Women In Prison
YCC	Youth Custody Centre

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THIRD REPORT

PRISON MEDICAL SERVICE

The Social Services Committee has agreed to the following Report:

I. INTRODUCTION

1. In May 1985 the Social Services Committee decided, with the agreement of the Home Affairs Committee, to undertake an inquiry into the Prison Medical Service (PMS). The PMS is part of the Home Office Prison Department and is the responsibility of the Home Secretary. We have examined the work of the Prison Medical Service in England and Wales, and to a lesser extent in Northern Ireland, and have received evidence about medical services in Scottish Prisons. We have also sought information about health services for prisoners in Sweden and the Netherlands, which we visited in April-May 1986 (see Annex 3).

2. We have received much written evidence, listed in Annex 1, from people working in the Prison Medical Service and their organisations, from a wide variety of other bodies, both medical organisations and bodies concerned with the welfare of prisoners, and from a number of former prisoners. We are grateful to all those who responded to our request for memoranda, and to those who gave oral evidence. In particular, we are grateful to Dr John Kilgour, Director of Prison Medical Services, both for the evidence he himself gave to us, and for the encouragement he has given to prison medical officers to give us their views directly.

3. Members of the Committee have made 19 informal visits to prisons in the UK. A list of the prisons visited is at Annex 2. During those visits we concentrated our attention on the hospital wings of prisons, and had meetings with medical officers, hospital officers, nursing staff, prison governors and inmates. We are grateful to the governors of all the prisons we visited for their cooperation and to everyone who gave up their time to talk to us. Many visiting consultants made time to join our discussions during these visits. We also visited Broadmoor Special Hospital and the Denis Hill Unit at the Bethlem Royal Hospital and express our appreciation of the efforts made by staff at both hospitals to enable us to reach a fuller understanding of their role in the treatment of mentally disordered offenders.

4. Early in our inquiry we appointed three specialist advisers for the inquiry. They are Robert Bluglass, Professor of Forensic Psychiatry, University of Birmingham; John Gunn, Professor of Forensic Psychiatry, Institute of Psychiatry; and James MacKeith, Consultant Forensic Psychiatrist at the Bethlem Royal Hospital. Their wise advice has been invaluable.

5. Ours is by no means the first inquiry into the Prison Medical Service. Various select committee reports have identified deficiencies in prison medical services and made recommendations to improve them. These include the Expenditure Committee's Fifteenth Report of Session 1977–78 which discussed the treatment of mentally disordered offenders in custody and alcoholics and persons with a drink problem.[1] The Home Affairs Committee covered much the

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[1] HC 662, Session 1977–78, paras 69–87.

same ground in 1980–81[2] and in 1934–84 touched on the issue of remands in custody for medical and psychiatric reports.[3] The Report of the May Committee in 1979[4] and the Butler Committee on Mentally Abnormal Offenders in 1975[5] made important recommendations about medical treatment of offenders. In 1964, a Home Office Working Party on the Organisation of the Prison Medical Service (the Gwynn Committee)[6] discussed, in particular, psychiatric services in prisons.

6. More recently, there have been reports of important inquiries relevant to the PMS as a whole. These include the First Report of the Advisory Committee on the therapeutic regime at HM Prison Grendon in 1985, the Holloway Project Committee Report, of July 1985, the Report of the Committee on the Prison discipline system chaired by Mr Peter Prior,[7] HM Chief Inspector of Prisons' report on Suicides in Prison[8] and the report of the review of suicide precautions at HM Detention Centres and HM Young Offenders Institution, Glenochil, published in 1985.

7. Serious criticisms have been levelled against the Prison Medical Service, not only in the course of our inquiry, but more generally. Some newspapers and periodicals have carried alarming stories about the standards of care, alleging neglect or worse by medical officers or hospital officers. More recently, a series of articles in the British Medical Journal by Dr Richard Smith, now reissued in book form,[9] attempted to describe and analyse many of the features of prison medicine and to compare facilities in prisons in England and Wales with those in other countries.

8. Although we have been told that some prison doctors are incompetent and out of touch with modern medical practice we are not seeking to prove that those now working in the prison service are bad at their job. We are aware that doctors in the PMS would vehemently deny the allegations which have been made about the quality of the care they provide. There have been no recent successful cases brought by prisoners alleging medical malpractice. This Report should not be construed as further criticism of prison doctors; it is written in the spirit of planning prison health care for the future. What is undeniable, however, is that there is a body of evidence that there is a lack of confidence in the PMS. The separation of the PMS from the mainstream of medical practice makes it vulnerable to allegations of professional isolation and low standards. The closed nature of prison establishments makes it inevitable that there will be allegations of cover-up of abuses. In view of some of the rumours we had heard, we were surprised at the generally good standard of care for physical ailments and the fact that access to treatment is often at least as readily available as for those outside prison. We have taken as a starting point in our inquiry the principle that prisoners are entitled to the same standard of medical care as would be available

[2] The Prison Service: Fourth Report of the Home Affairs Committee, HC 412, Session 1980–81, paras 41–46.
[3] Remands in Custody, First Report of the Home Affairs Committee, Session 1983–84, HC 252.
[4] Committee of Inquiry into the UK Prison Service, Cmnd 7673.
[5] Cmnd 5698, Cmnd 6244.
[6] The Organisation of the Prison Medical Service, Report of the Working Party, Home Office, 1964.
[7] Cmnd 9641, October 1985.
[8] Suicides in Prison, Report of HM Chief Inspector of Prisons, May 1984.
[9] *Prison Health Care,* Dr Richard Smith, BMA 1984.

to the community as a whole under the National Health Service (NHS). The PMS is at present understandably open to criticism that such standards are not maintained in prisons. Whether such criticisms are founded on fact or on rumour is not the point. The Government needs to be seen to be beyond reproach in its provision of medical care to prisoners.

II. THE PRISON ENVIRONMENT

9. Medical services in prisons cannot be considered in isolation. The PMS deals with the health of prisoners and, as in the community outside, health is affected by the environment. Many of the problems faced by the PMS, and many of the criticisms that are levelled at it, stem from the state of our prisons. That prisons are in crisis is now acknowledged by all. The principal factors in this crisis are overcrowding, old buildings, poor hygiene, an acute shortage of staff and traditional working practices.

10. The prison population now stands at 46,848 and has risen by 4,718 since 1979.[10] We are still faced with the appalling prospect of two or three men in a cell designed for one in the Victorian era, which has been repeatedly condemned in reports on the prison service. Worst affected are the old local prisons in the inner cities which are having to cope with an increasing and unpredictable influx of remand prisoners. In 1983, 17.6 per cent of the prison population was untried and the proportion still seems to be growing.[11] The number in prison who were untried on 28 February 1986 is estimated at 7,920.[12] As HM Chief Inspector of Prisons has stated—

> "... remanded inmates are held almost invariably in the oldest and most overcrowded prisons—and ... it is in the local prisons and remand centres that facilities and services are generally the poorest ... we are clear that much needs to be done before conditions are regarded as acceptable".[13]

11. Prisoners in many remand and local prisons are kept locked up in their cells for up to 23 hours each day. Surprisingly there is no recent research on the effect of this on the mental or physical health of inmates, but it is true to say that in some prisons inmates are being kept in conditions which would not be tolerated for animals. We are in no doubt that prolonged confinement of up to three people in a cell designed for one more than a century ago must have an effect on the inmates' emotional, physical and mental health and increase the level of tension in a prison unnecessarily. It almost certainly encourages violence and casual homosexuality with its inherent health risks. We were struck, during our visit to Scotland, by the ability of the Governor of Edinburgh prison, faced with the same sort of problems of availability of discipline staff as apply in prisons in England, to get virtually all inmates out of their cells and working for a considerable part of each day, with the cooperation of prison officers. We are disturbed by recent further closures of prison workshops in England and Wales. Prisoners are, by virtue of being in prison, denied liberty, and normal contact with their families and other people. Locking them up in their cells for all or most of the day can be interpreted as an

[10] HC Deb, 15 May 1986, Col 517*w* (The figures given are for 9 May 1986 and 30 April 1979).
[11] Report of HM Chief Inspector of Prisons, 1984, HC 589, Session 1984–85, para 2.11.
[12] HC Deb, 5 June 1986, Col 629*w*.
[13] Report of HM Chief Inspector of Prisons, op cit, para 2.12.

additional punishment and one which has potential implications for their physical and mental health.

12. The Chief Inspector has recently carried out a review of night sanitation in prisons. He concluded—

> "The sanitary arrangements in many penal establishments in England and Wales are uncivilised, unhygienic and degrading. This is particularly true of local prisons and remand centres where many inmates are locked in their cells overnight—and sometimes much of the day too—without access to toilets. In consequence they are obliged to use plastic chamber pots which have to be emptied out when they are unlocked—a procedure graphically referred to as "slopping out".
>
> The problem is exacerbated by overcrowding, which results in most of these inmates having to use their pots in the presence of one or two other inmates in the confines of a small cell. When the time for slopping out comes the prisoners queue up with their pots for the few toilets on the landing. The stench of urine and excrement pervades the prison. So awful is this procedure that many prisoners become constipated—others prefer to use their pants, hurling them and their contents out of the window when morning comes."[14]

Slopping out is dreadfully unhygienic. We are astonished that there are not regular outbreaks of disease in prisons. That there are not is to the credit of the prison authorities. Nevertheless, keeping prisoners locked for up to 23 hours per day in cells with no access to modern lavatory facilities is not an acceptable practice in 1986.

13. Virtually all witnesses have told us about the effect of shortages or unavailability of discipline officers. In remand prisons a large proportion of the staff on duty are engaged in escorting prisoners to and from court. The lack of sufficient prison officers in the right places at the right time affects health in prisons and the availability of medical treatment. The memorandum we received from the Institution of Professional Civil Servants (IPCS) stated—

> "Shortages in numbers of prison officers also create difficulties for medical staff and can interrupt the treatment available. If there are no prison officers available to bring an inmate from the cell to the doctor, the inmate does not see the doctor. If there are no prison officers available to escort the inmate to a hospital appointment, the inmate does not get to the hospital appointment."[15]

Dr Garwood amplified this in oral evidence—

> "Delays can occur when an arm gets broken or a leg gets broken. It may take time to get a prison officer into the prison in order to go on the escort. The staffing situation rests on a knife-edge."[16]

14. During this inquiry we visited prisons in Sweden and the Netherlands and, while we should not suggest that everything there is perfect, we were greatly impressed by what we saw. Prisoners always have a cell to themselves. During the daytime they are, for the most part, allowed considerable freedom within the

[14] ibid, paras 5.03–5.04.
[15] Ev, p279, para 4.8.
[16] Q1057, also Qs1072–8.

prison confines. Long-term prisoners are given plenty to do, in work or education. They leave prison after having had some preparation for life and work in the community. They are encouraged to maintain contact with their families and in some establishments there are special units for occasional weekend visits. Prison buildings may not be modern but they are well-kept: small things, such as pictures on the wall, make an enormous difference to the atmosphere. Appalling conditions are not an inevitable part of a prison system.

15. The dreadful state of our prisons, and in particular overcrowding, is largely a consequence of decades of neglect of prisons by successive Governments. The present Government is now trying to remedy this by a huge programme of prison building: 8,000 additional places are to be provided by the early 1990s.[17] This in itself will not be enough. As the Government accepts, there must be a change in sentencing policy and greater use of non-custodial sentences.[18] Present policy and particularly the tendency to remand accused persons in custody is causing acute pressure on the prison service and has a direct effect on prison medical services. **We recommend that, in its current inquiry into the prison system, the Home Affairs Committee examine the effect of the sentencing and remand practices of the courts on the size and nature of the prison population; the practice of locking prisoners in their cells all day; opportunities for work and regular exercise; access to satisfactory lavatory and washing facilities and the number and availability of prison staff.**

III. GENERAL HEALTH CARE

Examination on reception

16. The Prison Standing Orders require that every prisoner be given a medical examination on reception into custody.[19] This is usually conducted on the day of arrival but in some large remand prisons, where prisoners may arrive late in the evening, it may be deferred until the following day. The purpose of the examination appears to be to identify prisoners who are already receiving treatment which will need to be continued in prison, to detect and deal with infestation, and to identify bizarre behaviour which might be symptomatic of psychiatric disorder. In practice, it is often perfunctory to the point of uselessness.[20] According to the Association of Members of Boards of Visitors (AMBOV)—

> "at Wormwood Scrubs, it is not unknown for upwards of 50 inmates to be examined in the space of an hour".[21]

In our view, this is deplorable clinical practice and a waste of time.

17. In Geneva prison, routine compulsory medical examinations of this kind have been abandoned.[22] Instead, each prisoner is seen on the day of his arrival by a nurse who records treatment already being received, and gives prisoners an

[17] HC Deb, 24 April, col 187*w*.
[18] ibid.
[19] Prison Standing Orders, August 1985, Section 13.3(1).
[20] Qs174–7.
[21] Ev p293.
[22] P83B.

opportunity to indicate any problems.[23] In the Dutch and Swedish prisons we visited, prisoners were not automatically seen by a doctor on arrival. Instead of a very brief examination by a doctor, it might be more satisfactory for new inmates to be screened by a qualified nurse trained to administer a series of specially designed questions. Arrangements could be made for all new inmates who request it, or where behaviour or reports indicate medical investigation, to be seen by a doctor the day the day after their arrival, at a more leisurely pace. A doctor would need to be on-call to deal with urgent treatment such as the prescription of insulin for a diabetic inmate. This might go some way to "normalise" the prisoner's relations with the medical practitioner who would then not be seen, on first encounter, as a part of the prison apparatus, but rather as a doctor available to provide medical help to those in need of it. **We recommend that the Home Office consider alternatives to the routine medical examination of all prisoners on reception into custody, including screening by a qualified nurse.**

Sick parade

18. If prisoners feel unwell they are sent to the daily "sick parade" held at the prison hospital, or, in larger prisons, on the wings. In 1984–85 an average of 3,744 prisoners reported sick each day—about 8.5 per cent of the daily prison population. The percentage of women prisoners reporting sick each day was higher—over 30 per cent.[24]

19. Prisoners are not permitted to undertake even the simplest self-medication. While we can buy a bottle of aspirin when we feel unwell, prisoners have to go to the doctor. They are not allowed to keep in their cell so much as a tube of ointment for spots. This is clearly ridiculous. With the Prison Reform Trust (PRT)—

> "we doubt if there is any real benefit in a system which insists that prisoners must go to the dispensary when suffering from indigestion or a headache."[25]

It not only puts an unnecessary burden on the hard-pressed hospital officers who run the dispensary, but further cocoons prisoners from the realities of everyday life and ill prepares them for the pressures to which they will eventually return. Of course, there would be risks in allowing prisoners to keep analgesics in their cells. It might pose dangers for the suicidal and could possibly encourage trafficking.[26] Naturally, care would have to be taken that prisoners were not able to hoard drugs. We believe that, for the most part, the benefits of "liberalising" the regime in this way would outweigh the risks. **We recommend that doctors be given discretion to allow prisoners to keep in their cells limited quantities of simple drugs or medicaments.**

20. It is entirely sensible for prisoners to be seen by a hospital officer if they are only seeking simple medication. However, there is some evidence that prisoners are sometimes refused permission to see a doctor when they have specifically requested it. Ms Tchaikovsky of Women in Prison (WIP) told us—

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[23] P83D.
[24] Report of the work of the Prison Department, 1984–85, Cmnd 9699, App 6.
[25] Ev, p153, para. 3.4; also Q1148.
[26] Qs596–7.

"... A lot of prisoners' requests to see a doctor are vetted. A lot of prisoners' claims that they are ill are assumed to be malingering".[27]

Mrs Audrey Peckham of MIND referred to the case of Sarah Hewer, who died in Pucklechurch Remand Centre in 1985, where the inquest was told that she had been refused permission, in that case, by a nurse in the prison hospital, to see a doctor.[28] It is inevitable that there will be an element of malingering in some prisoners' requests to see a doctor. The nature of the prison regime and its monotony mean that prisoners are understandably tempted to seek to attend sick parade to try to get out of work, to seek sympathy or just for something different to do. Nevertheless, it is most important that the prisoner be given the benefit of the doubt. Prisoners are not free to decide how to manage their own time—for example a prisoner feeling unwell cannot take a day off work and stay in bed because he has a cold without medical approval. There is a responsibility on prison authorities to ensure that a prisoner who says he is unwell, for whatever reason, is able to consult the doctor. Only a medically-trained person is able to identify symptoms of more serious illness. The Prison Rules state—

"Every request by a prisoner to see the medical officer should be recorded by the officer to whom it is made and promptly passed on to the medical officer.[29]

Under the Prison Standing Orders—

"The names of prisoners who appear out of health, or who desire to see the Medical Officer, will be handed to him on his arrival, and he will attend those prisoners without delay. He will arrange that prisoners have the opportunity of making to him personally complaints or requests in relation to health".[30]

Prisons should never lay themselves open to the accusation that an inmate's health has been neglected or harmed by delay in receiving medical treatment. **We recommend that in all circumstances any prisoner asking to see a doctor should be able to do so, and that such requests should be facilitated by prison officers.**

Prison Hospitals

21. All prisons have an area described as the prison "hospital".[31] In most prisons this is little more than a sick-bay providing some accommodation for prisoner patients in wards and/or single cells, a place where medicines are stored and dispensed and consulting rooms for the medical officer and visiting specialists, including dentists. Many prison hospitals also contain one or more "protected rooms"—a room where fittings such as radiators are protected by fixed covers, and where the furniture, if any, cannot be damaged by a violent and disturbed prisoner. In some of the bigger prisons, the facilities are more elaborate: the "hospital" really is a hospital. Three prison hospitals have surgical units.

22. Prison hospitals vary enormously from establishment to establishment. In the words of the Prison Officers' Association (POA), conditions—

"range from excellent to downright disgusting".[32]

It is probably a reasonable generalisation that facilities are better in prisons for

[27] Q529.
[28] Qs656–7; Ev p122.
[29] The Prison Rules, 1964, S.I. 1964, No. 388, Section 17.2
[30] Prison Standing Orders, op cit, Sections 4(1) and (2).
[31] Ev P1.
[32] Ev p241, para 3.1.

long-stay prisoners than in large urban local prisoners serving short sentences and prisoners on remand. Certainly the best—and least used—facilities that we saw were at Featherstone, a new Category C training prison. The worst were probably at Bedford, an overcrowded Victorian local and remand prison.[33] Staffing seems to bear little relation to need. On paper at least, the staffing of these two prison hospitals was almost identical—4 hospital officers, which does not allow continuous night cover. Each prison is served by a local General Practitioner (GP). It is in local and remand prisons that the needs are the most acute. Any prison hospital might have to cope with, say, the care of an epileptic or diabetic inmate, a person suffering from a heart condition, as well as treating patients who have received injuries or are recuperating from an operation. Local and remand prisons also have to cater for numbers of severely disturbed people, some of whom are mentally ill or mentally handicapped, and undertake the task of providing medical or psychiatric reports for the courts on prisoners remanded in custody for that purpose. Their hospitals are often intolerably overcrowded and severely understaffed. Lavatory and washing facilities are often no better in the prison hospital than in the main prison. **We recommend that the Home Office take immediate steps to ensure that patients in prison hospitals have access to proper lavatory and washing facilities at all times.**

23. Dr Kilgour told us that the Prison Department had identified three areas, Featherstone among them, where it might be practical to "cluster" several establishments.[34] It might be possible for several nearby establishments to share one hospital facility. It is important to distinguish here between real hospitals and sick-bays. Every prison establishment should have a sick-bay. It may not be necessary for every sick-bay to have trained nursing staff on duty at all times, day and night, but we do think it important that a trained nurse should be on-call in every prison, 24 hours a day, in case of emergency. This is not the case at present.[35] In bigger and busier prisons a sick-bay is not enough. There should be a proper hospital with as many trained staff of all disciplines, and as good facilities as in an NHS hospital unit of similar size. Here certainly some clustering or centralising of resources will be necessary. A prisoner in a small establishment who needs constant nursing supervision would be moved to the nearest prison hospital. To some extent this happens already. **We recommend that the Home Office acknowledge the difference between sick-bays and hospitals; decide which prison establishments require more elaborate hospitals and staff them accordingly; and take steps to ensure that there is 24 hour on-call nursing cover in all prison establishments.**

Surgery

24. Very minor surgery can be done by a doctor in his consulting room. Prisons are no exception to this, and simple procedures are carried out by prison medical officers using local anaesthetics in most prison hospitals. The normal practice of the PMS in regard to any more complicated surgery is to arrange for the prisoner to go to the nearest suitable NHS hospital for the operation, and then be returned at the earliest opportunity to convalesce in the prison hospital. Where prison

[33] Ev p83–84, Ev p157, para 8.7.
[34] Qs1396–7.
[35] Ev p297.

hospitals are not staffed at night, or the prison is located a long way from a town with a suitable hospital, a prisoner may be first transferred to another prison and thence to hospital for an operation.[36] From the evidence we received and from our visits to prisons, it appears to us that a prisoner in need of surgery is likely to receive treatment, usually in an NHS hospital, at least as quickly as if he or she were outside prison, and sometimes more speedily.

25. Sending a prisoner to a NHS hospital for treatment is costly. All hospital treatment facilities are provided free of charge but the hospital authorities are not responsible for the security of the prisoner. The prime responsibility of the prison authorities is security and normally a prisoner attending a local hospital is guarded at all times by prison officers. A category A prisoner may require two officers at all times on a shift system. The cost to the prison service in manpower is clearly very high.[37] In the interests of security and economy, therefore, some non-emergency surgery is done in surgical units inside prison.

26. There are surgical units at Parkhurst Prison, Isle of Wight, Walton Prison, Liverpool and Wormwood Scrubs Prison, London. A further unit, at Grendon, closed in 1982. During the time of our investigation, only the Parkhurst unit—the only one which takes Category A prisoners—was in operation, and here, according to the Head of Nursing Services—

"operating facilities and standards are avowedly inadequate".[38]

One of the two post-operative wards was closed, apparently because of staff shortages. The unit is shortly to be modernised.[39] The busiest unit, at Liverpool, has just been reopened following major refurbishment.[40] The Wormwood Scrubs unit has been out of action since 1981 and may not re-open till 1991.[41] Nearly all the surgery in these units is done by NHS consultant surgeons working in the prison on a sessional basis. The units are staffed by trained nurses, including some experienced theatre sisters. Agency nurses are taken on when necessary.[42]

27. As the Home Office is unable to identify the costs of the surgical units,[43] it is impossible to compare the costs of treatment inside and outside prison. Somewhat surprisingly, the Head of Nursing Services maintained that—

"It is debatable whether surgery inside prison is a cost-effective proposition".[44]

and pointed out that the temporary loss of two of the units had led to no serious problems. In contrast, Dr Kilgour seemed certain that surgery within prisons was cheaper, and, of course, more secure.[45] It is Home Office policy to maintain surgical units within the Prison Service, at the three regional centres.[46] We endorse this approach. In emergency cases and where the prisoner poses no security risk, it is appropriate to use NHS facilities. But where the cost of escorts would be

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[36] Q413.
[37] ibid.
[38] Ev p5, para 8.
[39] Q411.
[40] HC Deb, 24 April 1986, col 199*w*; 3 June 1986, cols 519–520*w*.
[41] Q411; Ev p5.
[42] Q948.
[43] Q415.
[44] Ev p5.
[45] Q414.
[46] Q411.

escessive, and where the nature of the prisoner makes his treatment in an NHS hospital a potential risk to the general public, it seems sensible for treatment to take place within the prison system. It is most important that the surgical facilities in prisons are brought up to date. This has now been done at Liverpool. **We recommend that the surgical units at Wormwood Scrubs and Parkhurst be modernised as soon as possible.**

Radiography and EEG

28. Every large prison in England and Wales has a room with simple X-ray facilities. This means that a prisoner with, say, a fractured wrist can be X-rayed quickly and inexpensively within the prison walls. For more complicated X-rays, involving, for example, a barium meal, a prisoner would have to be escorted, at considerable cost, to a specialist NHS facility. In the NHS even the simplest X-ray requires a qualified radiographer with at least three years' training. In prisons they are, for the most part, done by hospital officers who have merely undergone a two-week course in darkroom techniques. In the view of the Royal College of General Practitioners (RCGP), this is—

> "potentially extremely dangerous".[47]

The College of Radiographers said—

> "It is of great concern to the radiographic profession that equipment is being entrusted to inexperienced and unqualified persons, however well meaning they may be".[48]

The risk is not only to the prisoner but to the officer doing the X-ray.[49] Mr Barker, Head of Prison Nursing Services, stressed that only minor X-rays on the extremities are involved.[50] In fact, we were told in one prison that chest X-rays are also taken, and the College of Radiographers suggest that skull radiography is not unknown.[51] The College also points out that the danger of radiation is as high or even higher in extremity work than in other areas.[52] Perhaps surprisingly, Dr Trafford of the Prison Medical Association (PMA) told us—

> "on the whole, this part of the service is adequate for what it does".[53]

In the view of the College of Radiographers the system is—

> "run more for the benefit of those who organise the prison service than for the consumers of that service".[54]

It is clear that the PMS itself is not entirely happy with the situation. Dr Kilgour told us that there were to be discussions later this year with the Faculty of Radiologists and the Society of Radiographers.[55] Mr Barker wrote in his submission—

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[47] Ev, p80; also p82; Q313.
[48] P28, p6.
[49] Q314; Ev p297.
[50] Q467.
[51] P28, p5.
[52] ibid.
[53] Q172.
[54] P28, p7.
[55] Q468.

"In general, staff with specialist roles, such as dark room assistants, compounders, radiographers, should have the required specialist qualifications for their particular work".[56]

We agree. **We recommend that X-rays be taken only by qualified radiographers in approved conditions.**

29. Similar considerations apply to the administering of electro-encephalography (EEG), which is carried out in some prisons. **We recommend that EEG equipment should only be used by staff properly trained, to NHS standards, in their use.**

Pharmaceutical Services

30. The dispensing of drugs for the PMS is done by a network of pharmacists, pharmacy technicians and hospital officers trained as "compounders". The Chief Pharmacist is accountable to the Director of Prison Medical Services. There are full-time pharmacist posts at 14 large prisons: Birmingham, Bristol, Brixton, Durham, Grendon, Holloway, Liverpool, Manchester, Parkhurst, Pentonville, Risley, Wakefield, Wandsworth and Wormwood Scrubs. There are four part-time pharmacists posts at Leicester, Leeds, Rochester and Bedford. (Only three of these are filled).[57] Curiously, prison pharmacists are employed on NHS terms of service.[58] Each pharmacist is responsible for supervising smaller establishments in the area.[59] In addition there are eight pharmacy technicians[60] and 46 compounders.[61] Dr Kilgour indicated that Home Office policy was now to phase out compounders while increasing the complement of pharmacy technicians.[62] Compounders are being encouraged to take the pharmacy technician qualification. Mr Barker pointed out that when a hospital officer was working as a compounder he was unavailable for general hospital officer duties.[63]

31. The number of pharmacists employed by the prison service has apparently not risen since 1966, while the prison population has risen by over 40 per cent.[64] It is a token of their efficiency that they have managed to cope with a greatly increased workload. Dr Kilgour believed that an increase would be "desirable".[65] Others would go much further. Mr Bland of the IPCS, a full-time pharmacist at Wormwood Scrubs, told us—

"the workload seems to have escalated almost to the point of the system breaking down. We are skating on quite thin ice".[66]

The IPCS in their paper suggested that there is no evening or weekend cover and that—

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[56] Ev, p6.
[57] Q476.
[58] Q1086.
[59] Ev p278, para 4.4.
[60] Ev, p2.
[61] Q476.
[62] ibid.
[63] Q479.
[64] Ev, p279, para 4.4.
[65] Q478.
[66] Q1081.

"Medical Officers in many establishments rarely, if ever, see a pharmacist".[67]

Prison doctors do not have ready access to advice from the pharmacist on new drugs or possible side-effects. The IPCS recommends a "modest increase" to 20 full-time staff. Mr Bland said that there was a need for new full-time posts in the Midlands, South-East and North Regions.[68] He believed that one good full-time pharmacy technician might be more use than two part-time pharmacists.[69]

32. Evidence supplied to us on the cost of prison medical services[70] does not enable us to identify the exact cost of pharmaceutical supplies to the prison service. We understand that there are no central purchasing arrangements. A form of voluntary "limited list" is in operation. Dr Kilgour told us—

"My policy has been to tell the pharmacists and the medical staff that they should follow, in general terms, and as closely as possible, what the practice is in the NHS".[71]

Where a doctor felt strongly that a drug outside the list was required, it would not be forbidden. Some prisons operate their own formulary. At Bedford, for example, the part-time Medical Officer and his colleagues operate a limited formulary similar to that which is used in their practice outside. This can, of course, cause friction where a prisoner is denied a drug which he has become accustomed to taking outside.[72] **We recommend that the Prison Department review the number of prison pharmacists and pharmacy technicians and consider whether it would be cost-effective to employ pharmacists on a sessional basis and to use NHS ordering and supplying arrangements.**

Medical Records

33. According to Mr Cooper of the IPCS, which represents prison medical officers, medical records in prison are—

"appalling: they really are quite disgusting".[73]

Dr Kilgour told us—

"I have been very unhappy with the medical documentation system in the Prison Department".[74]

There appear to be four different issues: first, the number and nature of the record sheets themselves; secondly, the confidentiality of medical records; thirdly, storage and retrieval of records within the prison system; and fourthly, problems of transfer of NHS records to a prison and vice versa.

34. Details of a prisoner's medical examination on entry and history are recorded on form 1150, the basic prison record, and are stored centrally. That form also records the doctor's view as to the fitness of the prisoner for work. It is

[67] Ev, p279, para 4.5.
[68] Qs1082–3.
[69] Q1084.
[70] Appendix 1, para h(vi).
[71] Q405.
[72] Ev p292; Qs1087–1090.
[73] Q1066.
[74] Q427.

not routinely available to the prison medical officer.[75] When an inmate reports sick, details of treatment are entered on a small record card (Cardex). If a prisoner requires longer treatment, that card does not have sufficient space for detailed observations so a hospital case paper is started, which is similar in form to the A4 folders used for NHS records. We have been told by a variety of doctors, and by Dr Kilgour, that this is unsatisfactory and that the three records are not brought together.[76] Dr Kilgour told us that "the first preliminary steps" have been taken to review medical documentation.[77] This is clearly long overdue. **We recommend that immediate steps be taken to devise a single form of medical record, capable of holding all case papers, for all prisoners.**

35. In respect of women prisoners, we were surprised to be told that medical treatment cards are inadequate to record, for example, details of the menstrual cycle.[78] **We recommend that immediate steps be taken to devise and bring into use medical records suitable for the recording of women's medical state.**

36. We regard it as unsatisfactory, and ethically questionable that medical information should be recorded on the main prison records which are accessible to all prison staff.[79] There seems to be no reason why the main prison record need contain any medical information other than the medical officer's opinion on the prisoner's fitness to perform work, or, for example, a warning about potential risk of suicide. **We recommend that the medical records on prisoners be kept in the prison hospital under the auspices of medical staff, not in the main prison record.**

37. It is difficult for prison medical officers to obtain details of medical treatment given to a prisoner during a previous prison sentence, or when he is moved from one prison to another.[80] This seems to be because there is no central documentation store and we have been told during our visits to prisons that it is often extremely difficult to trace prisoners' medical records. We have received disturbing evidence from former prisoners about lack of continuity of treatment when prisoners are moved to another prison.[81] That is indefensible. **We recommend that urgent steps be taken to centralise, possibly on computer, prisoners' medical records, and to devise a system whereby records can speedily be transferred from prison to prison and be retrieved when a person is reconvicted and enters prison again.**

39. Then there is the issue of the interchangeability of medical records with the NHS. If a prisoner receives a sentence of two years or longer, arrangements can be made for his NHS record to be transferred to the Home Office. For long-term prisoners therefore, there ought eventually to be no reason to suppose that there is a permanent lack of continuity of medical documentation. But such prisoners might have been imprisoned on remand for some time before conviction and sentence. For them and for all other remand prisoners and for all inmates sentenced to less than two years in prison, there is no formal transfer of medical

[75] Q1067.
[76] eg Q1067.
[77] Q427.
[78] Ev, p297; Qs 433, 434.
[79] Q1071.
[80] Ev p280, paras 6.1–6.3.
[81] eg P45.

documentation with the prisoner from the NHS to the prison service. For many this will be of no real consequence in practice, if an inmate is healthy, or if he tells the medical officer on admission of the type of treatment he has been receiving. But for the prisoner who does not give the medical officer any medical history at his initial examination, and in particular for the inmate who has been receiving psychiatric treatment, or has a history of depressive illness, the absence of knowledge about his medical background could have a significant effect on the speed and adequacy of the treatment he receives in prison, or in extreme circumstances, could perhaps lead to a suicide attempt which otherwise could have been prevented.

39. On leaving prison too, there are problems with regard to the transfer of medical records. An inmate receiving a course of medical treatment at the time of discharge is offered by the prison medical officer a letter to his GP, or if he does not have a GP, a "to whom it may concern" letter.[82] Dr Kilgour acknowledged the unsatisfactory nature of these arrangements.[83] We have received evidence that a significant proportion of inmates actually refuse such letters on release.[84] Such inmates are likely to be those about whom Dr Maurice Rosen gave evidence.[85] Dr Rosen told us a sorry tale of lack of response or help from the PMS at, in particular, Pentonville prison, where he had sought information about the medical treatment given in prison to homeless men who attended his surgery.[86] We are dismayed that a well-meaning GP has experienced inadequate cooperation from the PMS. We attach particular concern to the provision by the PMS of details of any treatment that might have been given to homeless people, since, as we say elsewhere in this Report, such people are an increasingly worrying phenomenon. For alcoholics or drug dependants, homeless, inadequate, without a permanent GP, the absence of cooperation by the PMS with a doctor who seeks information on their behalf is particularly disturbing and an instance of the lack of "throughcare" by the prison service as a whole, for which the PMS must take a share of the blame. **We recommend that prison doctors make greater effort to communicate to a prisoner's GP details of treatment given in prison and respond helpfully to any request from a GP for such information.**

Chiropody

40. Chiropody was not raised as a major cause for concern during any of our visits, by medical officers, prison staff or inmates. We were therefore surprised to learn from the Prison Governors' Branch of the Society of Civil and Public Servants (SCPS) that—

> "Governors in long-term and dispersal prisons have identified chiropody particularly as a continual source of prisoner complaints and administrative problems ".[87]

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[82] Q429.
[83] ibid.
[84] Martin E, Colebrook M, Gray A, Health of Prisoners admitted to and discharged from Bedford Prison, BMJ 1984, 289, 965–967.
[85] Qs714–747.
[86] Q730.
[87] Ev, p255, para 8.1.

Mr Bone of the Prison Governors' Branch suggested that many prisoners arrive with sometimes quite serious foot problems and that—

> "some of the conditions in our prisons in fact contribute to that kind of problem, because they are not in a position to bathe as regularly as they would like".[88]

According to AMBOV, Boards of Visitors regularly receive complaints from prisoners who find prison-issue plastic shoes uncomfortable.[89] Chiropody is not a recognised specialism for hospital officers, although we were told on visits that some officers develop skills of this kind, and according to the Prison Governors' Branch—

> "there is no consistant policy concerning the use of registered chiropodists as visiting consultants".[90]

We recommend that the Prison Department examine carefully the points raised by the Prison Governors' Branch of the SCPS regarding the provision of chiropody services and make it the practice to recruit chiropodists on a sessional basis.

Dentistry

41. In 1984–85, 71,320 inmates were referred for dental treatment.[91] In English prisons, dental treatment is provided on a sessional basis by general dental practitioners contracted to the local Family Practitioner Committee (FPC). Only in Northern Ireland are full-time dentists employed, for reasons, we gather, of economy.[92] Two dentists cover all of the Province's prisons. In England there are now 99 visiting dentists.[93] As with any NHS patient, they have a responsibility—

> "to provide and complete satisfactorily all the treatment necessary to secure dental fitness".[94]

The only difference is that the NHS charge is met by the Home Office and not by the prisoner. The prison establishment provides a room with a dentist's chair and basic instruments, while the dentist has to provide and pay for all necessary dental staff, materials, laboratory expenses and any instruments not provided.[95] According to the Home Office—

> "most establishments have a fully equipped dental surgery".[96]

However, according to the Association of Prison Dental Surgeons of the United Kingdom, in the past a lack of consultation between the prison establishments and the dentist has led to the purchase of incorrect equipment and a "considerable waste of money".[97] During our visits we talked to several visiting dentists and dental nurses and, on the whole, they seemed satisfied with the equipment provided.

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[88] Qs958–964.
[89] Ev p293; Qs1090–1.
[90] Ev p255, para 8.1.
[91] Cmnd 9699, Appendix 6.
[92] Appendix 7.
[93] Appendix 1, para (d).
[94] P61.
[95] P60, P61.
[96] Ev, p3.
[97] P60.

42. In the view of the British Dental Association the present arrangements for providing dental care to prisoners are "efficient and effective", although they testify to the growing pressure on prison dentists as a result of the expanding prison population. They point out that many prisoners come from a section of the population that does not regularly visit a dentist.[98] The Association of Prison Dental Surgeons suggest that to meet patient demand there would have to be "a considerable increase" in the number of dental clinic sessions.[99] Both Associations mention that problems have been exacerbated by the cancellation of some sessions as the result of prison officer shortages and industrial disputes. In several prisons, inmates complained to us that they had had to wait for months for dental treatment, although prison medical officers assured us that this would not be the case if their need was urgent.

43. The paper of the Association of Prison Dental Surgeons raises a concern that has recently received some coverage in the press—

> "It would appear that cash limits have been imposed resulting in some Prison Dental Surgeons being unable to provide treatment because if they did the budget would be exceeded".[100]

We put this to Dr Kilgour. He told us—

> "there should be—and as far as I am aware there is—no case where somebody is denied treatment which he would have been given had he been outside in the community, from NHS sources, giving as a reason lack of resources . . . There are budgets, but they are target budgets, not ceilings".[101]

He accepted that complaints had been made and referred to a recent case at Hindley where the dentist had been told to cut down the number of clinics. According to Dr Kilgour, "a fairly good compromise"[102] has been reached. We hope that this does not mean that the dental care given to inmates has been compromised. We were concerned by Dr Kilgour's comment that the dentist in question was—

> "commencing treatment which he could not always guarantee to complete, because the patient might be on the move".[103]

It is important that a prisoner is not denied necessary dental care just because he is likely to move on to another establishment.

Mother and Baby Units

44. In 1984–85, 71 women gave birth while serving a term of imprisonment. In all but one case, they were transferred to an outside hospital for the delivery and returned to the prison establishment afterwards.[104] These women pose both practical problems for the Prison Department and an ethical dilemma. It is generally agreed that where possible babies should not be separated from their mothers, and that separation from her baby will prejudice the mother's

[98] P61.
[99] P60.
[100] ibid.
[101] Q480.
[102] ibid.
[103] ibid.
[104] Cmnd 9699, Appendix 6.

rehabilitation,[105] but there is little doubt that prisons are not suitable places for children to grow up in.[106] Some argue that the way out of this dilemma is to release all women from prison on their confinement, possibly on parole.[107] Ms Tchaikovsky of WIP proposed—

> "hostels for mothers in the community, on the lines of bail hostels, where a mother would be taught home economics to help to bring up the kid".[108]

Lord Glenarthur thought it "unrealistic" to suggest that all prisoners who give birth be released on parole, and said—

> "so much depends upon the individual circumstances".[109]

We agree that it would not be right, or wise, to parole every woman, however serious her crime, merely because she has a baby. On the other hand, we do think there is scope for greater flexibility. Most women with young children are unlikely to reoffend, particularly if their release, and their contact with their baby, is conditional on good behaviour. We notice that in 1984–85, nine women were released, under the Royal Prerogative of Mercy, on the grounds of advanced pregnancy.[110] **We recommend that the Home Office establish better domestic environments for women offenders with young children; and that the Parole Board treat pregnant women and women with young children more sympathetically when considering applications for parole.**

45. At present there are three units in English prisons for mothers and babies with about 74 places in total.[111] As Dr Kilgour said, this is "not an overgenerous provision".[112] There are units at Holloway and Styal which take babies up to the age of nine months, and a unit at Askham Grange, an open prison, where babies may stay till 18 months. There have been complaints about the regime in these units. The British Paediatric Association (BPA) states—

> "It is understood that physical conditions are a cause for concern, with mothers not having the opportunity to prepare feeds for their babies, spending long periods confined to one room with the baby with inadequate play material and visual stimulation for both mothers and babies".[113]

The National Council for Civil Liberties (NCCL) refers to—

> "disturbing allegations about the treatment provided for pregnant women and for babies in the prisons' mother and baby units".[144]

Ms Sear and Ms Tansy, formerly prisoners at Styal, suggest that at the unit there—

> "a lot of stress was caused by not being able to pick up their babies when they wanted to. They were told when to feed, when to change and when to do almost everything for their children".[115]

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[105] see P36.
[106] see Q1335.
[107] Q562; Qs569–71.
[108] Q571.
[109] Q1338.
[110] Cmnd 9699, Appendix 6.
[111] see P36.
[112] Q1335.
[113] P36, para 4.2.
[114] Ev, p228; see Qs812–814.
[115] P45A.

46. We visited the units at Styal and Holloway in the course of our inquiry. The Holloway unit has seven single rooms for mothers and babies and 12 dormitory beds for pregnant women, and takes both sentenced and remand prisoners. Its premises are dreadfully cramped and it is due to be moved shortly to purpose-built facilities separate from the main prison buildings. During our visit we were told that the new unit was ready but the move was delayed because of staff shortages. The Styal unit has places for 14 mothers and babies, although only eight were filled at the time of our visit. Agency nurses are taken on according to need. The facilities are better, more attractive and less cramped than at Holloway, although most of the women had to share three-bedded rooms. The regime seems to be more ordered than at Holloway, with all the women, if they are well, going out to work during the day from a week after delivery. This may mean that they are less prone to boredom and depression but also that they are unable, for example, to breastfeed their babies on demand. We were disturbed to find very few mothers, either at Holloway or at Styal, who were breastfeeding their babies. It must be said that none of the women we talked to, at either unit, made any complaint about the regime or the nursing care that they were given.

47. As the BPA points out, women in prison—

"constitute an obstetrically at risk group".[116]

There have been complaints that the antenatal care provided by the PMS is inadequate. According to the Faculty of Community Medicine of the Royal College of Physicians—

"antenatal care is frequently disrupted several times. The safety of the woman and her child is often disregarded in a way consistent with the mores of the last century".[117]

Madeleine Blackburn, a health education teacher at Holloway suggests—

"certain antenatal tests considered routine in an obstetric unit or general practitioner unit outside the prison are not always made available either by Holloway or referral to an outside hospital, eg ultrasound tests, certain blood tests etc".[118]

Usually, mother return to prison 48 hours after delivery. It is essential that they have full access to NHS postnatal and paediatric care, because babies should not be put at risk because their mother has committed an offence. We welcome the research project that the Home Office has recently commissioned into the physical and psychological development of babies born to mothers in prison.[119] **We recommend that the Home Office extend its research into the health of babies born to mothers in prison to cover the antenatal and maternity care offered to women prisoners.**

Environmental Health

48. The PMS was originally established to control the spread of disease in prisons—or more precisely from the prisons to the local community[120]—and it has

[116] P36, para 5.1.
[117] P31.
[118] P23A.
[119] Qs1335–6.
[120] Ev p168, para 2.1.

performed its task remarkably well. In view of the insanitary conditions that prevail in some prisons and the serious overcrowding, it is quite extraordinary that there has never been a serious epidemic. It must be said that the prison service's record is considerably better than the NHS in this regard. Even during the height of the dirty protest in Northern Ireland there were no cases of enteric infection. Credit for this must go to the prison staff.[121] The risk of a major outbreak of disease in the future cannot be discounted.

49. It is the responsibility of a prison medical officer to advise the governor on environmental health issues. His duties include inspecting prison kitchens, including the menu and the food served to prisoners, and warning the governor of any health hazards. For the most part prison medical officers have no special training to do this.[122] Many medical officers told us that they did not feel qualified to judge whether, say, a blocked pipe was a serious health risk. The PMA wrote—

> "It would be logical for the Home Office either to open its doors to local health authority Community Physicians and Environmental Health Inspectors or to appoint such officers of its own to ensure that the hygiene of prison establishments fall into line with other public buildings which are not Crown property".[123]

At present environmental health officers have no right of inspection although they are normally invited in if a problem is detected. Dr Kilgour suggested that—

> "even if there is nothing going wrong . . . [managing medical officers] should contact the environmental health authorities and invite them to come in and see the establishment . . . I would like to see an open-door policy".[124]

Mr Powell of the Prison Governors Branch of the SCPS made a powerful plea for the removal of crown immunity from prisons.[125] Removal of crown immunity could give a statutory responsibility for hygiene to local environmental health officers. Legislation is now before Parliament to remove crown immunity from NHS hospital kitchens. Lord Glenarthur told us that crown immunity in prisons was "a live issue".[126] **We recommend that the Government remove responsibility for hygiene in prisons from prison medical officers and crown immunity from prison kitchens and hospitals. We further recommend that the role of Regional and District Medical Officers be extended to enable them, as specialists in community medicine, to play a part in the maintenance of environmental health in prisons.**

AIDS

50. The PMS is now being faced with a new problem in the form of AIDS. This is a subject on which there is much emotion and, as yet, too little public information. The mortality risk in a full blown case of AIDS is extremely high. However only 10–15 per cent of those who carry the HTLV III virus will develop this syndrome. The virus is of low infectivity, being transmitted by direct blood

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[121] Ev p241, para 3.2.
[122] Ev p37, VIII.1; Qs800–801.
[123] Ev p37, VIII.2.
[124] Q55.
[125] Q964; also Ev p200, para 6.1; Ev p269, para 28; Ev p293.
[126] Q1342.

contact between an infected individual and another. In practical terms this means that the route of transmission is via dirty hypodermic needles, transfused infected blood, pooled infected serum, and traumatic sexual intercourse (which is commoner among homosexuals than heterosexuals).[127] Simple precautions relating to the handling of blood, scrupulous sterilisation of all nursing and surgical instruments, the use of condoms in sexual intercourse, the reduction of promiscuity, and the avoidance of drug addicts handing on dirty needles, could reduce the size of the AIDS problem significantly and quickly.

51. As yet there has only been one diagnosed case of AIDS within the prison population but the numbers are bound to grow over the next few years.[128] Dr Kilgour predicted that there would be half a dozen cases of AIDS in the prison system by the end of the year.[129] Those who are seriously ill will be transferred to hospital: the problem for the PMS is how to cope with prisoners who show early symptoms of AIDS or who are between episodes of acute illness.[130] It must be emphasised that the problem is not how to protect other people from AIDS sufferers, but how to protect AIDS sufferers from infection. The Prison Department is planning to build an isolation unit for 12 patients (4 single cells and an 8-bedded ward) at Brixton Prison. It has "contingency plans" for a similar unit in the North, at Risley.[131] Dr Kilgour told us that in addition there would be—

> "two or three . . . long-term prisons which have facilities which we can adapt towards isolation for suitable cases".[132]

In our opinion, prisoners with fully-developed AIDS who need to be isolated to avoid risk of further infection, ought to be transferred to NHS hospitals. **We recommend that the Home Office, in close consultation with the DHSS, reconsider whether the present plans for developing isolation facilities for prisoners with AIDS are appropriate.**

52. At present there are some 30 prisoners known to be HTLV III antibody positive.[133] The real number of prisoners carrying the virus is likely to be much higher. Dr Kilgour told us that there was "no question" of routine blood testing in prisons.[134] It was up to the individual doctor to decide whether to encourage an at-risk patient to be tested and testing should only be done with the prisoner's full, and informed, consent. He assured us that he was in very close contact with his colleagues in the DHSS and suggested that it would be unwise, and improper, for the PMS to pioneer a policy of compulsory testing where this was not adopted in the community as a whole. We agree. It seems right in this case for the PMS to follow the general lead set by the DHSS. Rightly, in our view, the PMS has placed the emphasis on education. Guidance has been issued to governors and medical officers and will be updated as necessary;[135] selected psychologists are attending courses in counselling AIDS carriers at St Mary's Hospital in London.[136] A special

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[127] eg E D Acheson, AIDS: A challenge for the Public Health, *The Lancet,* March 22 1986.
[128] Ev p364, para 8–9.
[129] Q439.
[130] see Q440.
[131] Ev p364, para 10; Qs440–1.
[132] Q441.
[133] Ev p364, para 8.
[134] Q442.
[135] Ev p364, paras 4–5.
[136] ibid, para 6.

one-day course for prison hospital staff has been arranged at Wormwood Scrubs and may be repeated.[137] Lord Glenarthur assured us that there was "absolutely no complacency" about AIDS.[138]

Hepatitis B

53. For the present, Hepatitis B is in many ways a more worrying problem than AIDS for the PMS. In 1984–85 there were 152 cases of acute hepatitis B and 240 known carriers among the prison population.[139] Dr Kilgour reckoned that this was "a considerable underestimate of the real numbers".[140] The Home Office Guidelines for the management of hepatitis B[141] specify that acute cases must be isolated in the prison hospital and that carriers may be left in the main prison only under certain conditions—in single cells or in communal cells with other carriers. Evidence that we have been sent by a former prisoner at Wakefield Prison suggests that this rule is not always strictly adhered to.[142] Like AIDS, hepatitis B is transmitted by direct blood contact between an infected individual and an uninfected one: the usual route being via dirty needles and hence its high prevalence in drug addicts. Once the infection has been established, it has a much higher mortality than AIDS. At present the only sensible policy is an educational programme to try and prevent cross infection. As the Chief Inspector said in his 1984 Report—

> "There is a need for a concerted campaign to alert inmates to the consequences and dangers of drug abuse".[143]

Prisoners must also be warned of the risks involved in homosexual activity.

Health Education

54. Despite being mainly young prisoners are not a healthy group. A study at Bedford prison in February and March 1984 showed that 46 per cent of prisoners had active medical problems on reception into custody.[144] They have often made little use of health care advice in the past. Smoking is very common among both prisoners and prison staff.[145] Many prisoners are overweight.[146] We received many complaints from prisoners about the quality of the food in prisons. There seems to have been an improvement in the nutritional quality of prison food, and particularly in its fibre content, in recent months, but much that we saw did look stodgy and unappetising.[147] In many of the more overcrowded prisons, opportunities for exercise are limited[148] and personal hygiene made difficult by the inadequate sanitation facilities. The potential for health education in prisons is considerable but it has to date been given very little attention.[149] **We recommend**

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[137] ibid, para 7.
[138] Q1356.
[139] Cmnd 9699, Appendix 6.
[140] Q438.
[141] Appendix 4.
[142] P45.
[143] op cit, para 3.05.
[144] Martin E, Colebrook M, and Gray A, op cit.
[145] Ev p80; Ev p84.
[146] Ev p37.
[147] Qs1134–9.
[148] Q1143.
[149] see P23.

that additional resources be made available to establish a comprehensive health education programme for prisoners and staff throughout the prison system.

IV. MENTAL HEALTH

Reports to Courts

55. In the period 1 January 1984 to 31 March 1985 prison medical officers prepared for the courts 9,102 psychiatric reports and 219 physical health reports on persons remanded in custody for medical assessment.[150] In the big remand prisons, report writing represents the bulk of a full-time medical officer's workload. In Brixton, for example, in the same period, 3,184 psychiatric and 23 physical reports were prepared. The number of reports required clearly affects the time that a medical officer can spend in assessing each prisoner, and must affect the quality of the reports produced. Only 40% of medical officers have some qualification in psychiatry.[151] A considerable number of psychiatric reports are prepared by doctors who are not psychiatrists. The Forensic Senior Registrars' Group told us of their—

> "great concern . . . about the poor psychiatric skills shown by some members of the Prison Medical Service, some of whom are approved for the purpose of making recommendations [under the Mental Health Act] despite having no psychiatric qualifications".[152]

Dr Kilgour assured us that some full-time medical officers are very experienced in such work even though they do not have formal psychiatric qualifications.[153] This is not enough. The courts may not be fully aware that the psychiatric reports they receive are frequently prepared by doctors without psychiatric training and qualifications. The contents of a psychiatric report may be a major factor in deciding whether a person is sent to prison, or whether a hospital order or a probation order is made. They may well provide mitigating evidence. We were dismayed that Dr Kilgour was not able to give us a categoric undertaking that the Prison Department was aiming to provide such reports in all cases by a qualified psychiatrist.[154] We realise that this could not be achieved overnight, particularly in London, but we feel it should be given the highest priority. **We recommend that the Home Office set a date by which all psychiatric reports prepared for the courts, or for the Parole Board, will be by doctors with recognised training and qualifications in psychiatry.**

56. We are firmly of the opinion that too many people are being remanded to custody for medical assessment. Certain types of persons, such as those accused of very violent offences, will always need to be kept in custody before trial but for many remand in custody is not necessary. Without doubt prisons are not the best place to assess the psychiatric state of a person: there must be a risk that diagnosis will in some cases be distorted by the fact of imprisonment.[155] Probation officers are rarely consulted by prison medical officers.[156] The opportunities for involving other professions—psychiatric nurses and social workers, and psychologists—in

[150] Cmnd 9699, Appendix 6.
[151] ibid, para 278.
[152] P102; see Ev p267, para 16.
[153] Q34.
[154] Q34, Q399.
[155] eg Ev p135–6; P92.
[156] Ev p262, paras 3–4; Qs984–8.

the assessment process are almost non-existent. The Home Office has just reissued the booklet "The Sentence of the Court" which describes the options open to the courts.[157] In some circumstances the court may make attendance at or admission to hospital a condition of bail.[158] In its Report on Remands in Custody in 1984, the Home Affairs Committee recommended that the courts make more use of this power.[159] Where bail is inappropriate, the courts may remand the accused to hospital for a report under Section 35 of the Mental Health Act 1983. To date this power has not been used to its full potential.[160] **We recommend that magistrates and judges make more use of the alternatives to imprisonment for an accused person needing psychiatric reports.**

57. If an accused person is suffering from mental illness or mental impairment a Crown Court may remand him to hospital for treatment, under Section 36 of the Mental Health Act. A Crown Court or a Magistrates Court may remand an accused person believed to be suffering from mental illness, psychopathic disorder, mental impairment or severe mental impairment to hospital for a report (Section 35). This provision has to date been very little used.[161] It appears that a court may not remand both for psychiatric reports and for treatment at the same time.[162] This seems illogical and impracticable. **We recommend that the interaction of the provisions of Section 35 and Section 36 of the Mental Health Act be re-examined in order to allow the two functions of remand to hospital for report or treatment, to operate simultaneously.**

58. During our visit to Sweden and the Netherlands we were very interested to learn about their methods of psychiatric assessment of offenders. Members of the Committee visited the Clinic of Forensic Psychiatric Medicine in Uppsala in Sweden and the Pieter Baan Centre in Utrecht in the Netherlands. We were most impressed by what we saw. The procedure is roughly similar in both countries. If the courts ask for a psychiatric report the accused will be examined by a local psychiatrist either in a remand prison or in the community. If it seems that a fuller assessment is necessary, the court may send the accused to a special secure clinic for close observation and assessment by a multi-disciplinary team of doctors, nurses, psychologists and social workers, over a number of weeks. The Pieter Baan Centre, which serves the whole of the Netherlands, assesses about 200 people a year for 7 weeks each. In Sweden 600 people are sent to special assessment clinics (of which Uppsala is one) each year, for a period of 4–6 weeks. In both cases the report that is presented to the court includes not only an assessment of the accused's mental state and level of dangerousness but recommendations for treatment, and, if the accused is sent to hospital, the report will be passed to his doctors. Obviously this system is not cheap but it is effective. It not only allows the court to make a much better informed judgement and ensures that offenders who need treatment get it, but as a result it offers a much greater degree of security to the public.

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157 The Sentence of the Court, HMSO 1986, paras 12.3–12.5; Q1304; see also Ev p316.
158 S.14(3) or S.26 Magistrates Courts Act, 1952.
159 First Report, 1983–84, HC 252, para 51.
160 Ev p317–318; Ev p298; P92, p4.
161 Ev p317–18.
162 see P92, p4.

59. There is much in the Dutch and Swedish systems of assessment which we would do well to emulate. It is probably not appropriate for us to set up a whole new network of assessment centres on the Uppsala/Pieter Baan model, although the possibility of an experimental clinic of this type might usefully be examined by the Home Office and the DHSS. We already have the basis for a proper assessment system in the Regional Secure Units. During our inquiry we visited the Denis Hill Secure Unit at the Bethlem Royal Hospital. In terms of security and professional expertise in many disciplines it is very similar to the assessment clinics we saw abroad. Clearly if they were to be used on a regular basis for the preparation of reports for the courts, the Regional Secure Units would have to be extended and given additional resources. We have complained before about the time it has taken for Regions to provide the 1,000 secure beds agreed by the Government.[163] The story of the Secure Units is a sorry tale: the DHSS has shown itself incapable of making Regional Health Authorities (RHAs) do what they do not feel inclined to do. Again, we record our concern. 633 permanent secure unit beds will be open by the end of the year.[164] It is unlikely that this will be enough to cope with an increased assessment role. It may well be that the 2000 secure beds originally recommended in the Butler report will now be necessary. **We recommend that the Government recognise the key role in the psychiatric assessment of offenders which could be played by Regional Secure Units and reconsider urgently the number of planned places in secure units.**

Sentencing

60. When advised that a person before it is suffering from a mental disorder, the court may use certain powers under the Mental Health Act.[165] If the person is convicted of an offence punishable with imprisonment, the court may make a hospital order under Section 37 of the Act, allowing an offender to be taken to a mental hospital and detained there until he is discharged by his doctor or by the Mental Health Review Tribunal. Where the court considers the offender a danger to the public, it may make a restriction order (under Section 41) by which the patient will only be discharged with the Secretary of State's permission or by a special Mental Health Review Tribunal chaired by a judge. If the value of hospital treatment is in doubt, for example, the court may, under Section 38, make an interim hospital order detaining the offender for a limited period subject to subsequent review by the court. Alternatively, the court may (under Section 37) make a guardianship order placing the offender under the guardianship of either the local authority social services department or some person approved by them such as a relative, which may enable a mentally disordered person to remain at home or in a hostel where the alternative would be admission to hospital. For those convicted of a less serious offence, the court may make a probation order with a requirement that the prisoner submit to psychiatric treatment.[166]

61. There provisions ought to ensure that no mentally ill person requiring hospital treatment is sent to prison. Unfortunately they do not. Little use has been made so far of guardianship or probation orders. A hospital order cannot be made unless there is a hospital which is willing to accept the offender as a patient. Where there is a difficulty, the court may, under Section 39 of the Mental Health Act,

[163] eg Fourth Report, 1983–84, HC 395, Public Expenditure on the Social Services, paras 41–46.
[164] Ev, p315, para 21; Ev,p319.
[165] Ev p316.
[166] Powers of Criminal Courts Act 1973, s.3 as amended by the Mental Health Act 1983, Sch.4.

require the appropriate Regional Health Authority to provide information about hospital facilities in the region, but it cannot require the RHA to provide a hospital place. Much depends on the willingness of health authorities, and of individual consultants and their nursing staff, to take responsibility for someone who may be a very difficult patient. To encourage health authorities to fulfil their responsibilities properly, the Expenditure Committee recommended in 1978 that the DHSS pay for the accommodation of mentally disturbed offenders who are in prison.[167] In 1982 the Home Affairs Committee recommended that health authorities be required by law to provide beds for patients on whom the courts make hospital orders.[168] Neither recommendation was accepted by the Government. Both are attractive suggestions but we suspect that alone they would not achieve their aim. For the most part, the problem stems from the fact that the doctor preparing the report for the courts (where this is not an NHS consultant) does not himself have access to any NHS in-patient beds and may be quite out of contact with the local community psychiatric service. **We recommend that the Home Office, in consultation with the DHSS, take steps to provide, as soon as is practicable, for all psychiatric reports required by courts to be prepared by consultants with control of appropriate NHS facilities.**

Sentenced prisoners

62. Everyone acknowledges that there are a number of mentally ill people in prison.[169] What is unclear is how large this number is.[170] Dr Kilgour told us that the Home Office was seeking to obtain "a snapshot" of the psychiatric make-up of the prison population on a particular date in 1985.[171] Detailed results of this survey are not yet available but preliminary findings suggest that there are about 1,500 male prisoners who suffer from some degree of mental disorder and that 250 of these are actually mentally ill.[172] How accurate this is is open to doubt.[173] As Dr Kilgour accepted—

"We need something far more done in depth".[174]

Nevertheless, the snapshot confirms the general belief that there are a considerable number of people in prison who should not be there. It is beyond question in our view that people who are mentally ill and severely mentally impaired as defined by the Mental Health Act should be in hospital and not in prison. Under Section 47 of the Mental Health Act, a prisoner who becomes mentally ill or whose condition deteriorates while in prison may be transferred to a psychiatric or special hospital for treatment (Section 48 allows for remand prisoners similarly to be transferred). In practice it may take a long time for a bed to be found. In 1984–85, medical officers recommend that 167 sentenced prisoners be transferred, but only 126 were actually transferred.[175] At Bedford prison, we were told that a severely disturbed prisoner had recently spent almost eight months naked in a stripped cell.[176] During our visit there, we saw a prisoner lying in a catatonic stupor with

[167] Fifteenth Report from the Expenditure Committee, 1977–78, HC 662–I, para 77; see Ev p254, para 9.5.
[168] Fourth Report from the Home Affairs Committee, 1980–81, HC 412, para 46; see Ev p156–7; Q789.
[169] Q1302.
[170] P92.
[171] Q68.
[172] Q417.
[173] Q236.
[174] Q1310.
[175] Cmnd 9699, Appendix 6.
[176] see Ev, p298; Ev p82.

only a sheet for covering in an empty cell smeared with filth. This is wholly unacceptable.

63. One ironical aspect of the present position is that, if the prison doctor begins a course of treatment, it may become more difficult to effect a transfer of that prisoner to the NHS since when the consultant psychiatrist, who might be able to offer a bed for that patient, visits him, his behaviour may be under sufficient control for him to appear well enough not to need admission to hospital. So a prison doctor may feel it is in the interests of his patient not to begin treatment. But if a prisoner is simply confined in a stripped cell in a violent state, either because the doctor does not begin medication, or because the prisoner has refused it, the NHS consultant and nurse visiting the patient with a view to admitting him as an in-patient, may refuse to accept him because of the awfulness of his state or his violent behaviour. This is a paradox which must be resolved.

64. Much of the problem again stems from the fact that the psychiatrists working in the prisons do not themselves have access to NHS beds. Dr Kilgour told us—

> "Some of the problems that we have had in the transfer of the mentally disturbed, the mentally ill, the mentally abnormal offender, to outside NHS hospitals, have occurred because in some cases the prison system had been using the consultant services of psychiatric consultants who did not themselves control beds. What I would like to ensure is that the psychiatric consultants whom we do employ should themselves be in control of NHS beds, so that if they make a recommendation they can follow it up by actually taking the patient. I think that this has to be a gradual change. "[177]

Some progress has already been made. We were impressed to be told of the regular sessions being done in Manchester and Liverpool prisons by teams of psychiatrists from local psychiatric hospitals including the Regional Secure Units. A close relationship has been achieved in the North West between local forensic psychiatric services and prison medical services. Elsewhere there is an urgent need for improved cooperation at local level between prison doctors and the NHS psychiatric services. **We recommend that immediate steps be taken to find hospital places for those prisoners whose mental illness or severe mental impairment fall within the terms of the Mental Health Act.**

Treatment within the Prison System

65. Only a minority of psychiatric cases in prison fall within the scope of the Mental Health Act. Only those who are severaly disordered, and in the case of psychopathic disorders, only those whose disorder is thought to be treatable, can be transferred to hospital under the Act. It must be assumed that there will always be a considerable number of significantly disturbed people in prison.[178] The treatment a doctor in the prison service is able to give a mentally disordered person is constrained by the prison environment. It is constrained primarily by the shortage of trained nursing staff.[179] Dr Trafford of the PMA told us that in a prison hospital of, say, 25 patients, there would usually be three hospital officers on duty during the day and one at night—

[177] Q59.
[178] see Q1306.
[179] Q791.

"their role is purely custodial... they cannot devote time to individual patients".[180]

Most of these hospital officers, it should be remembered, have no training in psychiatric nursing. There is no alternative to sedation or seclusion to control disturbed behaviour. The doctor is further constrained by the requirement that treatment must only be given with the patient's consent, except where his or someone else's life is in danger or where his condition will irretrievably deteriorate if treatment is not given.[181] When a violently disturbed prisoner refuses to accept treatment, the prison doctor has only one option: to place the prisoner in a stripped cell until he calms down. Dr Hindson from Risley told us—

"We have to seclude people far more often than our colleagues working in the NHS do. This then leads, of course, to a situation—which is understandable—that the patients feel more uptight or resentful or frustrated. Then we get into the circular position of management: the more we get into that situation the more we have to seclude".[182]

Dr Kilgour told us that prisoners who refuse treatment are a small but important group.[183] Dr Bowden of the Royal College of Psychiatrists (RCPsych) told us—

"It is something which comes up every day... We are giving treatment without consent on the common law defence of necessity... In prison, day after day, I inveigle, and sometimes give injections of anti-psychotic drugs to individuals who do not consent, something I could not do if I was in the NHS and would be sued if I did... I do it because it is important for the prisoner to have treatment to reduce their psychotic illness".[184]

Many doctors are not prepared to risk such conflict with the law and the condition of some prisoners suffers accordingly.[185]

66. There is some concern among prisoners' groups that difficult prisoners are diagnosed as mentally disordered just because they are control problems. According to PROP, RAP and Inquest—

"Many prisoners believe that being 'nutted-off' to a special hospital is one of the penalties faced by trouble-makers".[186]

Black community groups believe that black prisoners are particularly vulnerable to such misdiagnosis.[187] A joint paper from the Black Female Prisoners Scheme, the Rastafarian Advice Service and the Afro-Caribbean Mental Health Association suggests—

"The overdiagnosis of schizophrenia, the exaggeration of psychotic dangerousness and the excessive use of major tranquillisers to quell ethnocentric expectations of physical violence are all problems present both in ordinary psychiatric institutions as well as in the practice of the PMS".[188]

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[180] Q134.
[181] Q84.
[182] Q136.
[183] Q419.
[184] Q273.
[185] Q275.
[186] Ev p135.
[187] Ev p215–216.
[188] P51, p8.

67. Prisoners considered to be "psychopathic" pose a particularly difficult problem. There is great controversy about what is a psychopathic disorder and whether it responds to treatment. It is open to doubt whether psychopaths are better placed in prison or in hospital.[189] Certainly the hospital system is ill equipped to contain the large numbers that the prison service has to cope with, partly because it has insufficient beds and staff, and partly because the security requirements necessary for many of these patients are not available within the NHS. The Special Hospitals take a small number either directly from the courts or on transfer from prisons. A DHSS working party is currently examining the needs of such "hard to place" individuals.[190] There is an urgent need for research into the management and treatment of violently disruptive prisoners. We were told at the van der Hoeven and the van Mesdag clinics in the Netherlands, that prisoners with psychopathic disorders respond well to treatment, given generous staffing and a supportive environment. The Butler Committee recommended that special units should be built within the prisons for such patients.[191] Nothing has happened in that respect, although Grendon prison has continued to provide an excellent service for a small number. **We recommend the establishment of a number of pilot units for violently disruptive prisoners and a study into the characteristics of these inmates and the effect of different forms of management and treatment.**

68. Some witnesses have suggested to us that specialist regional units should be set up in certain prisons to cope with particularly difficult or disordered prisoners.[192] The PMA's paper states—

> "A case can be argued for the centralisation of specialist hospital units in regional prisons serving groups of satellite establishments. Such units would undoubtedly offer better treatment for the inmate and greater job satisfaction for the doctors involved. Unless the transfer of the mentally disordered into NHS hospitals can be improved there is a strong case for the approval of selected and upgraded prison hospitals as hospitals under the Mental Health Act".[193]

In oral evidence Dr Trafford of the PMA did not support the idea of designating prison hospitals under the Act—

> "I think that this would be inconsistent with the philosophy that we are working under that the mentally ill should be treated in a hospital and not a prison. I do not think it would really improve the lot of the patient very much".[194]

Dr Kilgour was of a similar view.[195] However he did suggest that some form of regional centralisation of resources was under consideration.[196] The danger of developing specialist units within the prison system is that it might become even more difficult to transfer mentally disordered prisoners out to hospital. The fear is that the NHS would use these units as an excuse for not themselves providing places for prisoners.[197] We give a cautious welcome to Dr Kilgour's suggestion provided that these regional centres have a strictly limited function: the treatment

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[189] see Q249.
[190] Ev p215; Q784–5; Ev p315, para 18(d); Q1163; Q1223; Q1306.
[191] Ev p255, para 10.2.
[192] see P92, p5.
[193] Ev p35, para V.1.
[194] Q173.
[195] Q85.
[196] Q1324.
[197] Ev p240, para 1.10; Q774.

of only psychopathic and mentally impaired prisoners, and the assessment of mentally ill and severely mentally impaired prisoners before their transfer to hospital. In other words, they must not become used for the treatment of severely mentally ill people who should be in hospital. It would be most important for these units to be properly staffed on a multi-disciplinary basis. **We recommend that the purpose of specialist psychiatric units within prisons be carefully defined before they are established and their role limited to ensure that those patients who ought to be in hospital are not kept in prison.**

Women Prisoners

69. Among women prisoners the level of psychiatric disturbance seems to be particularly high. According to the PMA—

> "they include the most disturbed women in the population outside of the Special Hospitals".[198]

Although only about 3 per cent of the total prison population, women prisoners pose a considerable problem. A high proportion of women prisoners are on remand, many of them very far from home.[199] A woman from the West Midlands, for example, is likely to be sent to Risley, perhaps 100 miles away. Many of the women remanded into custody are severely disordered and it may be extremely difficult to get them transferred to hospital.[200] Many more find themselves unable to cope with the stress of the prison environment. The tension in women's prisons is marked. "Acting-out" is common, even to the extent of self-mutilation.[201] Women seem to suffer more than men from the emotional strain of imprisonment and separation from their families. Women prisoners have no access to the few specialised psychotherapeutic units in the prison service. The level of prescription of psychotropic drugs to women prisoners is very high.[202]

70. The proportion of women in prison will probably grow over the coming years. The PMS will have to cope with a corresponding amount of psychiatric disturbance. As the PMA concluded—

> "A new approach is required to the problems of women in prison".[203]

During our inquiry we visited Hinseberg, the only closed prison for women in Sweden. We were told that there, while they have some of the most disturbed women in Sweden, they have very little "acting-out" and have had no incidences of self-mutilation. The difference between Hinseberg and, say, Holloway is that it is in a pleasant environment with sufficient trained staff and the women have plenty to do. "Acting-out" is not an inevitable phenomenon in a women's prison.

71. At Holloway, the psychiatric unit, C1 wing, has received much publicity over the last couple of years. It has been criticised and deservedly so. As Lord Glenarthur said the design of Holloway is—

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198 Ev p38.
199 Ev p178, para 6.4.
200 Ev p28, para 6.8.
201 ibid.
202 Ev p178, para 6.6.
203 Ev p58.

"pretty ghastly".[204]

C1 wing is totally inapropriate for the care of psychiatrically disturbed people.[205] At long last, in response to the report of the Holloway Project Committee, some improvements are being made. Lord Glenarthur told us that a new unit will be built immediately. Meanwhile, as an interim measure, the present unit is being improved by recessing the lights and radiators and removing the blind spot in each cell and by adding a special protected room.[206] This work was due to be finished by August.[207] A Senior Medical Officer has been appointed to manage the unit. These modifications are welcome but more fudnamental changes are vital. **We recommend that the Home Office give the highest priority to building the new unit to replace Holloway's C1 Wing.**

Grendon

72. Unique among British prison establishments is Grendon, a psychotherapeutic prison established in 1962. Dr Bowden of the RC Psych described it as—

"a jewel in the rotting crown of the prison service . . . the only prison which has acceptable standards of care" .[208]

During our inquiry we visited Grendon and, while we were impressed by much that we saw, we were saddened by the low morale of the staff. The number of prisoners has almost doubled since 1982 and the number of staff has not risen accordingly. In consequence the quality of care has diminished: the psychotherapeutic regime has been so diluted that Grendon is now little more than an ordinary prison run on tolerably humane lines. There are not enough discipline officers to lead the therapeutic groups and many are just left to their own devices. Dr Kilgour assured us that Grendon is to remain a psychiatric prison.[209] Following the recommendations of the Advisory Committee on the Therapeutic Regime at Grendon, the Prison Department is planning to reduce the number of prisoners, to build an acute psychiatric unit and is considering opening a wing for women prisoners.[210] We endorse these suggestions. Although selective and not demonstrably effective in stopping prisoners reoffending, Grendon has been shown to influence attitudes, reduce psychiatric symptoms and modify behaviour in prisons.[211] It also has a widespread beneficial effect on the rest of the prison system. We believe that Grendon has a valuable future as a specialist therapeutic facility and as a centre of excellence for the prison service as a whole. Grendon used to be a place of international renown. It would be a tragedy to let it become just another prison for want of resources. **We recommend that the Government implement the recommendations contained in the Report of the Advisory Committee on the Therapeutic Regime at Grendon, to provide an acute psychiatric unit and a women's wing, reduce the number of prisoners and ensure that funding and manpower is sufficient to maintain Grendon's special regime.**

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[204] Q1326.
[205] Ev p28, para 6.9; Ev p38, para X.1; Ev p215.
[206] Q1325.
[207] Q1328.
[208] Q265.
[209] Q416; see Q1323.
[210] Q417.
[211] Gunn J and others, Psychiatric Aspects of Imprisonment, Academic Press, London, 1978.

Inadequates

73. A major problem for medical services in inner city local and remand prisons is the increasing number of "inadequates", usually petty offenders, often remanded in custody because they are homeless, or serving recurrent short sentences for relatively minor offences. All have serious personality disorders; they may be alcoholics and/or burnt-out schizophrenics and/or mentally handicapped; often they are homeless. There are suggestions that the number of such people in prison is a direct consequence of the policy of closing long-stay psychiatric hospitals.[212] It may have more to do with a reduction in the amount of hostel accommodation in the inner cities.[213] What is clear, however, is that there is a body of people, some of whom are known to psychiatric services, and may at some time be in-patients, who drift between resettlement units, homelessness, hospital and prison. The offences they commit are often related to their alcoholism or their mental state. We have expressed our concern about this group before in our Report on community care[214] and in our Report on the Government's plans to close resettlement units and re-establishment centres.[215] They do not fit into the standard framework of society. Their recurrent presence in prison is probably a consequence of their social inadequacy more than of the nature of their offences—they have nowhere else to go and the courts have little obvious alternative to sentencing them to prison.

74. Many witnesses have referred to the need for some form of asylum, in the best sense of the word, for this group of people.[216] For many, it is probably true that prison povides almost a home, and it is likely that the medical attention they receive in prison is the only such treatment they get. Dr Rosen described to us the lack of doctors prepared to accept homeless people as patients.[217] One of the glaring faults demonstrated to us in the course of the inquiry is the inadequacy of the relations between prisons, including the medical service, probabation officers, social workers, GPs, housing authorities and community psychiatric services. Society as a whole derives little benefit from inadequate people being sent to prison—and their medical problems ought not to be foisted upon the PMS. Greatly increased provision needs to be made in the form of bail hostels, sheltered accommodation, primary care and psychiatric help for the growing population of homeless men and women. Long-term help is urgently needed for alcoholics in particular, and in this context we were dismayed to note the decision by the Home Office in November 1985 to cease funding detoxification and alcoholic rehabilitation centres.[218] The PMS should not be faced with a large body of alcoholics needing drying-out, and medical services in prison are not the appropriate agency to "cure" alcoholics—that is a long-term social need, not purely a medical one. The Parole Board has drawn attention to the key role in reducing recidivism among the homeless, including those with drink and alcohol problems, of the provision of suitable forms of hostel accommodation.[219] A coherent national policy is desperately needed. **We recommend that the Government, in conjunction**

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[212] see Q1214; P92.
[213] Q227.
[214] Second Report from the Social Services Committee, 1984–85, HC 13–I.
[215] Second Report from the Social Services Committee, 1985–86, HC 128.
[216] P33.
[217] Q716ff.
[218] HC Deb, 20 November 1985, cols 167–8.
[219] Report of the Parole Board, 1985, HC 428, Session 1985–86, paras 4–6.

with voluntary organisations, health authorities and local authority social services departments, give urgent priority to providing a suitable range of hostel and sheltered accommodation and help for people no longer capable of helping themselves.

Drug and Alcohol Abuse

75. In our inquiry last year into the misuse of drugs, we examined the services available to drug misusers in prison and visited the Wormwood Scrubs Hospital Annexe. Our greatest concern was that—

> "the time so many addicts spend in custody represents a wasted opportunity for tackling the problem of their addiction".[220]

We recommended that the Home Office make considerably greater effort to improve the help given to drug misusers in custody and examine ways of extending opportunities for parole, including the use of supervision with urine testing.[221] The Home Office's response to our Report showed a disappointing complacency.[222] In our view, the situation has since become worse, not better.

76. Estimates of the amount of drug abuse within prisons vary considerably. The PMA told us that it was "widespread".[223] The British Medical Association (BMA) suspected that it was increasing sharply.[224] However, the impression we have gained from our visits is that while cannabis may be quite commonly found in some prisons, the extent of hard drug abuse is probably exaggerated. We were pleased to hear that two of the doctors recently recruited to the PMS have experience of treating drug abusers.[225] On the other hand, we were horrified to hear at Winchester that training for prison officers in treating drug abusers had been stopped as an economy measure.

77. Some addicts have gone through withdrawal before they get to prison, in the police cells, but misusers may still be suffering from the effects of withdrawal when they are remanded into prison. In 1984–85, 3,737 prisoner (3,137 males and 600 females) were reported by medical officers to have some degree of drug dependence on reception into custody.[226] Many more probably go unnoticed and unreported. The policy of the prison medical officer is nearly always to leave the prisoner to withdraw, perhaps prescribing tranquillisers to ease the symptoms.[227] How to treat each patient comes down to the professional judgement of the doctor involved[228] and professional opinion is divided about the relative merits of a reducing regime and quick withdrawal.

78. Our primary concern is not with the medical care given to drug abusers in prison but with the absence, in all but a few establishments, of a sustained effort to deal with the psychological side of their addiction. As Dr Kilgour said, the PMS—

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[220] Fourth Report from the Social Services Committee, 1984–85, HC 208, para 65.
[221] ibid, para 69.
[222] Cmnd 9685, paras 45–55.
[223] Ev, p37, VIII.3.
[224] Ev, p28, 6.10; Q208.
[225] Q437.
[226] Cmnd 9699, Appendix 6.
[227] see Ev, p190.
[228] Q451.

"are very good at getting them off, but the follow-through is not very well done".[229]

On the whole this is a social service, not a medical problem. In its response to our Report on the Misuse of Drugs, the Home Office pointed to the therapy provided at five establishments (Grendon, Wormwood Scrubs, Holloway, Glen Parva and Feltham) as proof that a great deal was being done to help drug users in prison.[230] This is, as we said in our Report, a drop in the ocean.[231] The A5 Unit at Holloway has ceased to function. We know of no services at all for drug misusers on remand. Dr Kilgour agreed that the situation was not satisfactory.[232] Of course, as Dr Trafford of the PMA pointed out, not everybody with a dependency problem is anxious to sort it out.[223] But for those who are prepared to accept help, help must be available. There is clearly scope for greater involvement of prison probation officers[234] and of experts of all disciplines from outside. We were pleased to hear that the Association of Chief Officers of Probation (ACOP) has been conducting a survey of liaison between the PMS and the probation service regarding drug abuse, with a view to discussions with Dr Kilgour.[235] They told us of a scheme at Stoke Heath YCC in Staffordshire, involving close liaison with the local specialist NHS services.[236] At Manchester Prison we were told that representatives of a local voluntary organisation, regularly provided counselling within the prison. There is no reason why this should not happen everywhere.

79. During our visit to Sweden and the Netherlands, Members of the Committee visited three prisons which run special programmes for drug abusers: Österåker prison near Åkersberga, Hinseberg women's prison near Örebro, and Demersluis remand prison in Amsterdam. In both countries, drug abuse is seen as a major problem. A high proportion of prisoners are drug abusers and in most prisons drugs are in common supply. The special programmes which we visited are for prisoners who are motivated to give up drugs. In return for certain privileges and opportunities for parole, they enter a contract with the prison authorities undertaking not to take drugs and to cooperate fully with a programme of work and group therapy. The approach varies a little: in Österåker, for example, the emphasis is on psychotherapy, while Hinseberg's approach is behavioural. In Sweden, but not at present in the Netherlands, the contract is backed up by daily urine testing.

80. The growing number of drug abusers in our prisons is very worrying, but in numerical terms they pose a much smaller problem than alcohol abusers. In almost every prison we visited, medical staff stressed that alcoholism was, at the moment, a much greater problem than drug abuse.[237] In many prisons, Alcoholics Anonymous run successful groups.[238]

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229 Q448.
230 Cmnd 9685 para 51.
231 see Q810.
232 Q448.
233 Q205.
234 Qs450, 453.
235 Q992.
236 Ev, p263, para 15.
237 Ev p79, para 1.
238 Ev p300.

81. Many witnesses have told us that the main problem lies not in the treatment that drug and alcohol abusers receive while they are in prison but in the absence of any after-care following release. Most addicts are weaned off their addiction during a spell in prison but, more often than not, they are back on within a few days of release.[239] It is terribly frustrating for prison medical staff to see the work that they have done go to waste for want of any effective after-care and to see the same people return to prison again and again. There is of course a severe shortage of facilities for both drug and alcohol abusers in the community, but the blame cannot all be put on the social services. As Dr Rosen noted—

> "One is left with the feeling that insufficient effort is made by the PMS to look at the needs of prisoners and to realise that their work does not stop when the gates shut behind the prisoner upon his release".[240]

Of course, follow-up takes time and resources but it is essential if the "revolving-door" process is to be prevented. There are good projects, such as the Parole Release Scheme for prisoners at Wormwood Scrubs,[241] but these are few and far between. The Home Office gives financial support to 22 rehabilitation projects under the after-care grant scheme[242] but it has withdrawn financial support from detoxification and alcohol rehabilitation centres. This is extraordinarily short-sighted. Lord Glenarthur assured us that the Home Office was urgently considering how to develop the "through-care facility".[243] The Home Office's recent publication "Tackling Drug Misuse" reveals that the Prison Department is planning to produce a simple card with the telephone number of local treatment and rehabilitation facilities for prison medical officers to give to drug abusers who are about to be discharged.[244] This is totally inadequate. **We recommend that the Home Office take steps to improve liaison at a local level between prisons and drug and alcohol rehabilitation projects; extend the use of parole for drug and alcohol abusers on condition of attendance at a specialist facility; consider establishing pre-release hostels at selected prisons; and initiate a national study into the prevalence of drug and alcohol addiction within the prison population and its relationship to crime.**

Prescribing Practice

82. Outside the Prison Service, it is widely believed that drugs are used by prison doctors to an excessive degree, for purposes of control as well as treatment.[245] Media references to the "liquid cosh" are common. In response to the criticism, the Home Office has published, since 1979, statistics in the Annual Report on the Work of the Prison Department showing the number of doses of medicine administered in prison establishments.[246] Unfortunately, the manner in which these statistics are presented is unhelpful.[247] First, what is a "dose" is not defined. Secondly, the way in which the medicines are classified is confusing. They

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[239] see Ev, p190.
[240] Ev, p190.
[241] Q810.
[242] Ev p365–8.
[243] Qs1329–1333.
[244] "Tackling Drug Misuse: a summary of the government's strategy", 2nd edition, 1986, para 7.18.
[245] eg P51, p7–8.
[246] eg Cmnd 9699, p126–8.
[247] see Report of Chief Inspector, 1984, op cit, paras 2.22–4; see Q590, Q806.

are divided into five groups: (i) medicines available without prescription in the community; (ii) psychotropic drugs (defined as anti-depressants, sedatives and tranquillisers); (iii) hypnotic drugs; (iv) drugs acting on the central nervous system other than those in (ii) and (iii); and (v) other drugs and medicines. The same drug might be "psychotropic" or "hypnotic" according to the time of day it was administered.[248] Thirdly, the smaller prisons are grouped together to preserve the anonymity of an individual doctor's prescribing practice. Most notably, Styal is grouped with Cookham Wood. It has been suggested that as Styal has a reputation for "low" prescribing this masks the very high level of prescribing that is alleged to occur in Cookham Wood.[249] Women in Prison was led to question whether this choice of grouping was arbitrary.[250] Mr Bland of the IPCS pointed out that the current system takes a great deal of time and put in a plea for computer support.[251] Lord Glenarthur accepted that the present method of presenting statistics was "something we have to look at".[252]

83. The level of prescribing in prisons, and particularly in women's prisons,[253] is undoubtedly high, but then so is the incidence of psychological disturbance. The fact that prescribing levels are high is not alone enough to prove that drugs are used to "excess". WIP had no evidence of "forcible drugging" although their paper refers to—

> "an element of coercion in ensuring that drugs are taken once prescribed".[254]

Ms Shaw of MIND spoke of a—

> "widespread opinion that there are circumstances within a prison where drugs are used in the absence of symptoms of mental illness"[255]

but she accepted that reports were contradictory. As Mr Leadbitter of Inquest suggested—

> "One man's control is another man's therapy".[256]

In all probability prison doctors are on occasions pressurised by the prison establishment to tranquillise a difficult patient, less for his sake than for the sake of a peaceful prison.[257] Of course, when the alterative is locking a prisoner up in a stripped cell and leaving him to bang his head against the walls, medication may seem the humane approach. Nevertheless, the legal position is clear: a prisoner may not be given medication without his consent. On the whole, prison doctors seem to go to considerable lengths to ensure that they cannot be accused of acting improperly. There may well be exceptions to this scrupulousness but we believe that they are rare. **We recommend that consideration be given to introducing a procedure whereby a prisoner records his consent in writing to the administration of psychotropic medication.**

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248 Ev, p131; also Ev, p172.
249 Ev, p127–8; Ev, p131.2.
250 Ev, p127.
251 Q1085.
252 Q1262.
253 Q575.
254 Ev, p125.
255 Q652.
256 Q557.
257 Ev, p268. paras 22–24.

84. Prison doctors, like doctors outside, are under constant pressure from their patients to prescribe.[258] All the complaints that we have heard from prisoners indicate that they receive less drugs than they wish, not more. Many prisoners are taking sedatives, in various forms, when they arrive in custody and, of course, many may be heavy drinkers and smokers. Taking tranquillisers is a simple way of avoiding life's pressures, in prison and out. In prisoners' jargon, you can "do your bird on your pillow" and "sleep your time away".[259] Overall, the rate of prescribing, particularly of hypnotic drugs, has fallen in prisons over the last few years, as it has outside. As the Prison Reform Trust (PRT) suggests—

> "there seems little doubt that prison doctors have in general cut back severely on their use of drugs".[260]

There is concern that in some prisons prescribing policy may have undergone radical change almost overnight. Patients who had grown accustomed to receiving a drug were suddenly denied it.[261] As Mr Ward of Radical Alternatives to Prison (RAP) said—

> "being sentenced to prison should not mean being sentenced to a particular medical philosophy".[262]

Withdrawal from a tranquilliser is a painful process. In the community a patient may be offered counselling from a psychiatric nurse or relaxation therapy. These services are rarely available in prison.[263]

85. It is hard to see how the Prison Department could publish prescribing statistics in a way that was meaningful or allowed comparison with the community outside. The important thing is to protect prisoners from improper prescribing: publishing national statistics reveals nothing about individual cases. Certainly prescribing in prisons, as with other aspects of medical care, needs to be carefully monitored, and the Prison Inspectorate might usefully give close scrutiny to this area. Frankly we believe that compiling meaningless statistics is a waste of time and money. **We recommend that the Prison Department stop publishing statistics on prescribing by prison doctors.**

V HEALTH CARE STAFF

Nursing Staff

86. In the past, most of the debate about the PMS has concentrated on doctors; on their quality, training and involvement in management: very little has been said about other professions. Modern medicine is a multi-disciplinary affair. The report of the Gwynn Committee,[264] set up to examine the PMS, did not discuss nursing services at all. Nursing staff provide the greater part of health care within the prison system. The Prison Department employs over 1,000 full-time nursing staff (884 hospital officers and 145 nurses in December 1985) and only 98 full-time doctors. Prisoners' day-to-day contact with the medical service is primarily

[258] see Qs804–5.
[259] Ev, p125; Q556.
[260] Ev, p155.
[261] Ev, p155; Ev, p132, para 16.
[262] Q555.
[263] see Qs590–2.
[264] op cit.

with hospital officers not doctors. Many of our witnesses suggested that it is in nursing services that the PMS is most deficient and that an improvement in the number and quality of nursing staff would do more than anything anything else to improve the standard of medical care within our prisons.[265]

87. At present nursing services in the prisons are strangely structured. In women's prisons all the nursing staff are trained nurses. In the men's prisons, with the exception of a few female nurses in the surgical units, they are hospital officers who have undergone a short training course. This division seems to be little more than an historical accident. The Head of Nursing Services writes—

> "there would seem to be no adequate justification for the twofold structure, nor any good reason why women should not work in male establishments, and vice versa".[266]

The Home Office has therefore decided to work towards a unified service in which nursing care in all establishments, male and female, is provided by staff trained in both discipline and nursing skills.[267] The POA supports this policy.[268] Nurses will gradually be absorbed into the hospital officer structure and women hospital officers are now being recruited from the disciplinary side.[269] Mr Barker suggested that the title "hospital officer" might be replaced by "nurse officer" as in Scotland.[270]

88. We endorse the policy of the Home Office to move towards a unified nursing service. Not only will that be more equitable but it should put an end to the friction between discipline officers and nurses with no discipline training which has in the past been in evidence in Holloway.[271] We similarly endorse the policy of the Home Office to increase the use of female nursing staff in men's prisons and male in female prisons.[272] We were struck during our visit to Grendon by the significance placed both by staff in all grades and by inmates on the effect of the presence of women in the establishment on the behaviour of very disruptive male inmates. We suspect the same would be true of women's prisons.

89. The Home Office is also aiming for—

> "a substantial increase in the proportion of male hospital officers with nursing qualifications and improved training opportunities for unqualified hospital officers".[273]

In Mr Barker's words—

> "It is hoped that eventually all hospital officers will be qualified nurses, and the short term aim is to arrive at a proportion of 30 per cent".[274]

At present a little over 11 per cent of hospital officers have a nursing qualification—a considerable improvement over a few years ago.[275] The interim

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265 Qs212–214.
266 Ev p5, para 13.
267 Cmnd 9699, paras 282–284.
268 Ev p243; Q871.
269 Ev p5.
270 ibid.
271 Ev p296.
272 Q885.
273 Cmnd 9699, para 283.
274 Ev p5 para 12.
275 Q14; Cmnd 9699, para 279.

target of 30 per cent is to be achieved in part by direct recruitment of trained nurses and in part by encouraging hospital officers to go forward for training. We note that the Chief Nursing Officer of the DHSS has expressed concern about whether there is a sufficient pool of trained nurses in the country to enable the prison service to recruit many without there being a consequent detrimental effect on the availability of nurses in the NHS.[276] The emphasis will have to be for the most part on training hospital officers to professional standards rather than recruiting large numbers of NHS nurses.

90. During our visits, concern has been expressed to us by both nurses and hospital officers about the effect the changes might have on their career prospects. Mr Barker told us—

> "There is a great deal of anxiety from hospital officers within the prison service who see that by recruiting qualified nurses as hospital officers their own position might be jeopardised as regards promotion".[277]

During our visits we have been told by many hospital officers that they would like to obtain professional nursing qualifications, but that it was virtually impossible for them to do so. The Home Office is prepared to release officers for nurse training, but not at their normal salary;[278] instead they have to accept remuneration at the level of student grant.[279] For hospital officers with domestic responsibilities for a family and home this is not financially feasible. Nor is there any financial incentive in terms of increased pay for trained staff.[280] As the POA argues, there should be—

> "a realistic financial reward for those who take the trouble to achieve professional qualifications".[281]

We recommend the speedy introduction of a unified nursing service.

91. We have given some thought to the appropriate level and specialisation of training necessary for nurses working in prisons. We suspect that it may be neither necessary nor feasible to recruit large numbers of nurses at SRN level. Prisoners are mainly physically healthy and prison hospitals should not generally be seen as hospitals in the NHS sense. Much of the work of hospital officers in administering the prison hospital, liaison with the medical officers about arrangements for sick prisoners and issuing proprietary medicines does not require a high degree of nursing skill. We agree, to some extent, with Lord Glenarthur's view that there is a place in prison nursing for "medical assistants" with very basic training.[282] This can reasonably be compared with the UKCC's new proposal for a grade of nursing "aide" in the NHS.[283]

92. At present basic hospital officer training involves a 26 week course at one of the two training schools at Wormwood Scrubs and Liverpool prisons. We understand that a maximum of 36 officers can currently be trained each year.

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[276] Q26; Q1193.
[277] Q25.
[278] For rates of pay, see Appendix 1.
[279] Q1275; Ev p296.
[280] Q894.
[281] Ev p243.
[282] Q1273.
[283] Project 2000, United Kingdom Central Council for Nursing, Midwifery and Health Visiting, May 1986, paras 5.34–5.42.

Given the universal shortage of discipline officers and the number who can be released to be trained as hospital officers, that appears to be as many training places as the system needs at present.[284] During our inquiry we visited the training school at Liverpool and talked with staff and trainee hospital officers including some from Northern Ireland. We were impressed by the quality of what we saw and by the efforts which are now being made to include in the training course some experience of work in NHS hospitals, in particular local psychiatric hospitals and regional secure units.

93. We were impressed by the description we received during and after our visit to prisons in Scotland, about the arrangements made there for the training of hospital officers, who are known as "nurse officers".[285] In Scotland almost all the nurse officers are recruited from the ranks of discipline officers. They are then seconded to NHS nurse training schools for a period of 18 months, at the basic prison officer rate of pay before returning to work in the prison medical service. The qualification they obtain after this period of training is that of State Enrolled Nurse. In addition there are a few nurses with other nursing qualifications, including SRN and psychiatric nursing qualifications. There are no hospital officers in the English sense. We are surprised that training of nursing staff in prisons has developed along such different lines in Scotland from the pattern in England and Wales, and by how little knowledge there appears to be in England and Wales of the Scottish model. The Scottish example is worthy of study. **We recommend that the Home Office examine the arrangements made for nurse officer training in the Scottish prison service.**

94. The prison service needs the skills of fully trained nurses—for example, for the care of prisoners recuperating from operations, the staffing of the surgical units in the three prisons which have operating theatres, the administration of medicine and injections, and the observation of prisoners for whom psychiatric reports have been requested by the courts or of disturbed and mentally ill inmates. At present, hospital officers perform some tasks, such as the suturing of wounds, which in an NHS hospital would always be performed by a skilled nurse or doctor.[286] This is unacceptable. It is essential that sufficient numbers of trained nurses are available to perform nursing tasks. There is a particularly urgent need for psychiatric nurses. What percentage of hospital officers overall are trained nurses is less important than how they are distributed. It is essential in our view that every prison has a trained nurse on call at all times. In bigger prisons, with a proper hospital, there should be trained nursing staff on duty all day and night. Present staffing levels do not always allow even 24 hours hospital officer cover. Like doctors, nurses in prison need to be kept in touch with developments in the NHS. Regular in-service training, with secondment to NHS hospitals, including regional secure units is needed, and staffing levels will need to take account of in-service training requirements. **We recommend a review of the nursing needs of all prison hospitals and a comprehensive policy towards the level and type of nursing service needed in prison establishments.**

[284] Q21.
[285] Appendix 5, paras 6–8, Appendix 6.
[286] Ev p295.

95. The role of the Head of Nursing Services, Mr Peter Barker, is to advise the Director "on matters relating to the management of hospital officers and matters of common interest to the hospital and nursing staff". In other words his management responsibility is only for hospital officers not for nurses in the prison service.[287] This, in the opinion of the Royal College of Nursing, is an anomalous situation—

> "the establishment of a post to manage an integrated service is . . . essential and the grading and salary of such a post must be commensurate with its responsibility".[288]

Dr Kilgour believed that the post of Head of Nursing Services was—

> "considerably undergraded".[289]

Like his own post, it is to be considered in a grading review within the next few months. It is time to reconsider whether it is appropriate for the Head of Nursing Services to be subordinate to the Director of the PMS, and indeed for nurses to be subordinate to doctors at local level. According to Mr Strank who was Chief Nursing Officer of the PMS from 1974 to 1978 (a brief experiment at integrated management of nurses and hospital officers)—

> "The position of head of nursing should attract an appropriate Civil Service grade on a par with others occupied in similar management/advisory posts. It is important that the head of nursing should be seen as a member of a team of equals, not subordinate to a medical officer. It is no longer acceptable that nursing advice is filtered through a physician".[290]

The PMS has too long revolved around doctors. Hospital and nursing staff play a considerably greater part in actually providing health care to prisoners. This should be reflected in the management of the PMS. **We recommend that the post of Chief Nursing Officer be revived, with responsibility for an integrated service of nurses and hospital officers, and that nursing services be accorded equal status with medical services within the prison service.**

Psychologists

96. There are at present 85 psychologists working in the prison service. Only 8 are qualified as clinical psychologists.[291] They do not come under the PMS but under an independent Directorate of Psychological Services. As the PMA states—

> "There is a need, largely unmet, for clinical psychologists to assist in the assessment of inmates both for the courts and for the Parole Board".[292]

There is also potentially a major role for clinical psychologists as therapists in the treatment of mentally disordered prisoners, especially those suffering from behavioural disorders.[293] At present there is no grade in the Prison Service equivalent to that of Top-Grade psychologist in the NHS. Consequently, if a psychologist in the prison service gains a clinical qualification, he or she is likely to

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[287] Q337.
[288] Ev, p92.
[289] Q1373.
[290] P48.
[291] HC Deb, 13 June 1986, col 324*w*.
[292] Ev p37 para IX.1.
[293] see P22.

move out into the NHS. Dr Kilgour estimated that the PMS needed the services of about 20 full-time equivalent clinical psychologists across the country—

> "Whether they would be full-time employees of the Prison Department, or whether they would be hired on a sessional basis from the NHS is immaterial to me, as long as I can have the time and the work done".[294]

We understand that some NHS clinical psychologists already do sessions in prisons although the Home Office keeps no central record of these sessions.[295] The IPCS, which represents prison psychologists, thought this should not be encouraged.[296] We disagree. A full-time clinical psychologist would be needed in only a few of the busiest prisons. Instead of having a few full-time prison employees travelling from establishment to establishment it would seem more sensible to employ local NHS psychologists on a part-time basis probably by contract with RHAs. We appreciate that clinical psychologists are in short supply throughout the NHS and that it will not be possible for the prison service to find the equivalent of 20 full-time psychologists overnight. There will have to be close co-operation between the Home Office and the DHSS over this. **We recommend that the Home Office give priority to meeting the need for clinical psychologists within the prison service, and to facilitating close liaison between medical and psychological services.**

Medical Staff

General Practitioners

97. The bulk of primary medical care in prisons is provided by ordinary GPs who agree to work in their local prison for a number of hours each week. There are currently 107 of these "part-time medical officers" in post—10 short of establishment—of whom 65 spend less than 10 hours a week in prison.[297] Only 2 of them are women. In 88 of the 116 prison establishments in England and Wales a GP acts as a "managing medical officer", formally supervised by a full-time Senior Medical Officer at another prison but in practice left much to his own devices.[298] Those working in the larger prisons, where there are full-time medical officers, have a purely clinical role.

98. In Sweden we learnt that in some areas the prison authorities find it impossible to get local doctors to come into the prison. In one prison we visited the prison doctor lived 60 miles away and visited only once a fortnight. The prison service in the UK is very fortunate that GPs are willing to give their time to work in prisons. It is largely professionally unrewarding work, dealing with often unresponsive and hostile patients. It is not particularly well-paid: they have no security of tenure and are given no superannuation cover.[299] The PMS relies heavily on their good will. For the most part they provide a remarkably good service in trying conditions. However there are matters that could be improved.

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[294] Q482.
[295] HC Deb, 13 June 1986, col 324*w*.
[296] Appendix 10, para 3.1.
[297] Appendix 1, para (d), p2.
[298] Q59.
[299] Q148.

99. GPs appointed to medical officer posts are given no introductory training and few opportunities for in-service training at a later stage.[300] They are left to find out how to do their job as best they can.[301] Many of the part-time medical officers that we met told us that they would like to provide a better service to their patients in prison: they were hampered by a lack of information. At a national level, there is very little research on or evidence about the specific medical needs of prisoners, or about the effects of imprisonment on health.[302] At a local level much more could be done in the area of "medical audit". We were impressed by the descriptions given to us by two GPs (Dr Martin and Dr Joliffe) giving evidence for the RCGP, about their medical "audit" of their practices' work in prisons.[303] We believe that such a system of auditing their own work, similar to that done by many general practices in the NHS, could lead to a greater understanding by GPs of the medical problems of prisoners in their care, and of the treatment which is appropriate. **We recommend that doctors working in the Prison Service be encouraged to undertake "medical audit" and that the Home Office sponsor a national survey into the general health needs of prison inmates.**

100. The appointment of GPs to medical officer posts seems somewhat haphazard. Although each post is now advertised,[304] nearly all the part-time medical officers we met had inherited the job from a retiring partner.[305] Dr Kilgour told us that it was not as easy for him to get rid of a bad GP as he would like.[306] We believe that GP services in prisons ought to be planned in a more structured fashion. Rather than relying on advertisements and the appointment of "part-time medical officers" from amongst those local GPs who apply, contracts should be entered into between the local FPC and the prison for the provision of GP services to prisons. A suitable formula for payment for such services would need to be devised. The contracts would specify the number of sessions needed and the FPC would be responsible for arranging for one or more local practices to provide the services. **We recommend that steps be taken to replace the present individual contracts with local GPs with contracts with FPCs.**

101. That would, we believe, meet two criticisms of the present system. First, part-time medical officers' remuneration is not at present superannuable:[307] a GP who does a large amount of prison work may be financially at a disadvantage. The contract we envisage with the FPC ought to provide that the same superannuation arrangements would apply in respect of work done in prisons as are made for GPs' NHS work. Secondly, there would then be no need to appoint the GP as a "part-time prison medical officer"—insted he would simply be the local doctor and he would receive remuneration via the FPC rather than direct from the Home Office. He would clearly be seen to be the prisoners' doctor, rather than the prison's doctor, and ought himself to feel properly distanced from the prison management. We feel that the title of "medical officer" obscures the fact that they are ordinary general practitioners and reinforces the view common among prisoners that they

[300] Q286.
[301] Q291.
[302] Q924; Ev p280, para 7.5.
[303] Q296ff.
[304] Q59.
[305] eg Q286.
[306] Q60.
[307] Q148.

are part of the prison establishment. **We recommend that the title of "part-time medical officer" be abandoned and that General Practitioners working in prisons be known simply as doctors.**

Visiting Specialists

102. Specialist medical care in prison is provided by visiting consultants individually contracted to the Home Office on a sessional basis. The Home Office refers to this system as "functional integration". At present there are 250 of these visiting consultants of whom 170 are psychiatrists. The others are genito-urinary specialists (for some reason still referred to as venereologists by the Home Office), surgeons, radiographers, orthopaedic surgeons, dermatologists and anaesthetists.[308] Other specialists may be called in as necessary. Some of the visiting specialists are NHS consultants, others are "appointed specialists"—retired consultants or private practitioners. The whole system is remarkably vague. Dr Kilgour told us—

> "I was surprised to find when I came that there was very little in the way of solid contractual arrangements . . . we are now trying to make the whole system more business-like".[309]

The Regional Medical Officers in their evidence, criticise the practice of the prison authorities advertising for and recruiting their own visiting psychiatrists and state—

> "In our view it would be better if the requirements of the prison service for consultant psychiatrists were planned in collaboration with the NHS".[310]

We believe this would be true for visiting consultants of all specialties. Instead of the present haphazard system, it might well be more satisfactory for the prison authorities to negotiate contracts directly with health authorities, probably at Regional level. The RHA would undertake to provide the necessary number of visiting consultant sessions in each prison. These sessions would be specified in the job description of an NHS consultant working in the locality. In other words the Prison Department would buy in a service rather than individual people.[311] It has been put to us that there could be a risk in making the local health authority responsible for providing services in prison, in that the competing priorities for health authority funding could lead to prison work being neglected in favour of other medical priorities. Mr McGinnis of the DHSS told us—

> "There is no conceivable way it could work. The only way a combination of a contractual obligation to provide a particular service and the reimbursement of the cost of that service could work is if the local health authority was actually obliged to sell the goods that the customer wants to buy from it and to meet the standards specified by the customer . . . You do not have a built-in guarantee."[312]

This seems to us to be unwarrantedly pessimistic. Provided there is a clear contractual obligation on the RHA to provide the services needed in a prison, and with good regional liaison between prison authorities and RHAs, we see no reason

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[308] Appendix 1, para (d).
[309] Q59.
[310] Appendix 8.
[311] see Q843.
[312] Q1198.

why such arrangements could not be extended to all regular visiting consultant sessions in prisons. **We recommend that "functional integration" be taken a stage further by replacing the present haphazard arrangements with individual specialists, by a system of contracts with RHAs to provide a specified number of sessions in each prison.**

Full-time Medical Officers

103. The UK is the only country in the West where a body of full-time prison doctors are directly employed by the prison authority. In England and Wales there are currently 98 full-time prison medical officers—only 1 short of establishment —of whom 8 are principal medical officers, 24 are senior medical officers and 66 are ordinary medical officers.[313] The majority are over 50 and only 12 are women.[314] 29 have qualifications in psychiatry, 6 in obstetrics, 5 in gynaecology, 3 in pathology, 2 each in anatomy, neurology, public health and tropical medicine and 1 in anaesthetics.[315] In Scotland there are only 3 full-time medical officers, all at Barlinnie.[316] Elsewhere medical care is provided entirely by doctors from outside the prison service. In Northern Ireland there are 7 full-time prison doctors but they are employed by the DHSS(NI), not by the Prison Department.[317]

104. The traditional prison medical officer is something of a jack of all trades. He is expected to be a GP, a psychiatrist, an environmental health officer and a health service manager all in one. As the Regional Medical Officers point out, this is unrealistic—

> "A decision needs to be made about the role of prison medical officers. They cannot be experts in several different fields of medicine.... Each group of doctors involved in prison medicine will need further education not only to ensure that high standards are maintained in their clinical work but also to update them on legislative and other organisational changes affecting prisoners and prison authorities".[318]

The generalist prison doctor has played a valuable role in the past but his day may be over. Modern medicine is changing rapidly. We believe that in prisons as outside, the future will require increasing specialisation.

105. We have given considerable thought to whether full-time prison medical officers are really necessary. 88 of the 116 prison establishments in England and Wales do not have a full-time medical officer.[319] Much of the work that now is done by full-time medical officers could certainly be done by NHS practitioners. Our recommendations regarding psychiatric reports to the courts would alone greatly reduce their workload. However, there may be some prisons where a full-time doctor will continue to be necessary. These may include prisons such as Parkhurst, Wormwood Scrubs and Holloway with psychiatric units, and Grendon, which has always been run on a medical model. Full-time doctors would probably

[313] Appendix 1, para (c).
[314] Ev p369–370, Appendix 1, para (e).
[315] Appendix 1, para (c).
[316] Appendix 5.
[317] Appendix 7.
[318] Appendix 8.
[319] Q59.

be necessary in the regional units for personality disordered prisoners which Dr Kilgour is considering.[320] Most of these doctors will be psychiatrists but there may be a need for full-time doctors of other specialties. It is vital that those doctors should not suffer from the professional isolation that some prison medical officers now complain of. All the prison doctors that we asked said that they would welcome the opportunity of working outside the prison service for one or two sessions a week.[321] This might require some involvement of health authorities in the appointment process. In the long run we seen no reason why all prison doctors should not be directly employed by the local health authority.[322] **We recommend that eventually every prison doctor should work at least one day a week outside the prison setting.**

106. If prison doctors are to be contracted to work on a part-time basis in the NHS it will be necessary for them to have comparable terms and conditions of appointment and employment to NHS doctors. At present, prison medical officers are civil servants and their pay compares unfavourably with that of equivalent posts in the NHS.[323] A Principal Medical Officer receives £27,335 to £28,653 a year, a Senior Medical Officer £25,533 and a Medical Officer £16,597 to £23,815.[324] The basic rate of pay of a consultant is roughly similar to that of a Principal Medical Officer but over a third of consultants (and two-thirds by the time of their retirement) receive an additional distinction award of between £5,350 and £27,300 a year.[325] Prison doctors have access to no such merit awards,[326] nor, of course, to private practice. While they do receive a small environmental allowance, they are not eligible for the type of enhanced superannuation conditions accorded to NHS consultant psychiatrists in recognition of the stress involved in their work.[327] Prison doctors are even at a disadvantage when compared with other civil service doctors in so far as they receive no additional payment for the time they spend on emergency "on-call" duty and routine weekend duties.[328] The Treasury is currently considering a proposal for an "on-call" allowance, based on the rates charged by locums, of around £2,200 a year.[329] This would cost about £141,500 a year but it might save around £75,000 in locums' fees. The present situation is clearly unfair. As an interim solution, **we recommend that prison doctors immediately be given a reasonable "on-call" allowance in recognition of the extra hours they are expected to work beyond their contracted week.**

107. In the longer term it will not be enough just to increase the pay of prison medical officers to the level of NHS doctors: they must be employed on the same pay-scale, grading system and conditions of appointment as the NHS[330] and be eligible for merit awards. This is not a radical proposal: doctors in Special Hospitals, who are employees of the Government in a similar way to the PMS are

320 Q1324.
321 Ev p33, para II.2; Q128.
322 Q800.
323 Ev p26, para 4.3; Ev p209; Ev p277, para 3.4; Q1266.
324 Appendix 2.
325 Review Body on Doctors' and Dentists' Remuneration, 16th Report, 1986, Cmnd 9788.
326 HC Deb, 13 June 1986, cols 324–5*w*.
327 Ev p33, para II.4; Qs145–6; Q148; Q38.
328 Q38; Q144.
329 Appendix 3.
330 see Ev p33, para II.4.

already employed on NHS terms. The present division is a major disincentive to movement between the NHS and the PMS and discourages the recruitment of doctors of a high quality. In our opinion, it will be very hard for prison doctors to persuade their patients and the general public of their professional independence while their terms of employment suggest that they are primarily civil servants. **We recommend that prison doctors be employed on the same contractual basis as NHS doctors.**

108. The formal training now given to prison medical officers is almost non-existent.[331] There is a 3 day induction course for new appointments and a 3 day development course in management problems.[332] There is no training grade, in the formal sense, in the PMS and the opportunities for secondment for professional training in the NHS have to date been severely limited by the shortage of staff. Where secondments have occurred, they have been mostly to Special Hospitals, which, according to the South East Thames RHA Standing Working Group on Forensic Psychiatry are—

> "not in a position to provide education about the bulk of cases a prison doctor will see, nor about the important community aspects of forensic psychiatry".[333]

The career structure for prison doctors should include training grades and opportunities for continuing medical education. We welcome Dr Kilgour's efforts to involve the Royal Colleges in maintaining professional standards in the PMS.[334] Close contact is needed with universities and professional bodies. Education and research should be an integral part of prison medical life.[334A] **We recommend that provision be made in prisons for training grades, probably on a part-time basis, as well as consultant appointments. In addition we recommend that some prison appointments either in general practice or in psychiatry be linked to appropriate university departments.**

Doctors and Management

109. Much criticism of the PMS has focused on prison doctors' involvement in management. It is alleged that a doctor working in the prison service faces a conflict of loyalties between his responsibility to the prison establishment and his responsibility to his patient. A prisoner has been deprived of his liberty and is imprisoned as punishment for an offence. Nonetheless, he is entitled to medical attention. For a successful doctor-patient relationship, the patient must trust the doctor to act in his best interests. Many witnesses have told us that such trust is not possible in a prison situation. Some of these are campaigning for a "normalisation" of the prison regime. It is, at least, arguable that proper doctor-patient relationships can only work if they are "normal" relationships, that is, founded on the patient's trust of his medical adviser.

110. Nowhere is the potential conflict in the allegiance of the prison doctor, and the actual confusion about his role as seen by prisoners, more apparent than in the

[331] Q1061.
[332] Q42.
[333] P10.
[334] Q445; Qs1155–9.
[334A] see Appendix 9.

issue of punishment within prisons for offences against prison rules. No disciplinary adjudication may proceed unless a prisoner has been certified as "fit for adjudication" after being examined by a prison medical officer.[335] Punishment may not be imposed unless a prisoner has been certified "fit".Punishment in this context means cellular confinement.[336] According to the RCGP—

> "Prison doctors must be urgently disassociated from supervising punishment of prisoners. Nobody can give personal care to inmates in an institution and at the same time supervise that establishment in punishing the inmates".[337]

All our witnesses from outside the prison service agreed with this view. On the other hand, prison governors and members of Boards of Visitors have indicated to us that they place importance on the word of the medical officer in passing someone as fit for adjudication. Prison governors must in the end take responsibility for punishments awarded. But they, understandably, want and need reassurance that a prisoner is fit, first to appear before them and understand the charges against him, and secondly, to withstand punishment without suffering physical or mental harm. Conversely, prisoners need to know that punishment will not continue if they are unfit to withstand it and that the medical officer is available to stop that punishment if it is making them ill.

111. There are two related problems. One is that there is some evidence, such as that given to the jury at the inquest into the death of Jim Heather-Hayes at Ashford Remand Centre,[338] that "fitting" prisoners for punishment is sometimes perfunctory and the medical examination is not sufficiently thorough to be certain that, for example, mental disturbance or suicidal tendencies on the part of the prisoner are noticed. The other is that doctors find the role of "fitting" prisoners as suitable to receive punishment at best distasteful and at worst unethical. NCCL has suggested[339] that the doctor responsible for the primary care of the prisoner should not at the same time be the doctor responsible for "fitting" him for punishment, and that instead a limited number of named doctors should be "certified" to give "advice" on (but not to authorise) fitness for adjudication and punishment. This might resolve the ethical problems of most doctors working with prisoners (although we doubt if there would be many doctors happy to volunteer for this new role of "certifying" doctor). But there could be a greater risk that the medical examination prior to such certification would be less thorough and that the doctor performing the task, who by definition would be unfamiliar with that prisoners' behaviour, might miss vital signs of disturbance or potential suicidal tendencies and thus put the prisoner at risk.

112. Any prisoner undergoing cellular confinement has to be seen at regular intervals by a doctor under Prison Standing Order No. 6(1). We understand the reluctance of doctors to be seen by prisoners to be taking part in the punishment process. We think Dr Kilgour's suggestion that the Prison Rules be amended to enable the prison governor to ask advice of the doctor treating the patient along the lines "give any reason why cellular confinement is contra-indicated for

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[335] Prison Rule 46(3).
[336] Q65.
[337] Ev p82, para 8.3.
[338] Ev, p135, p231.
[339] Ev, p232.

medical reasons"[340] has much sense. A governor should have to ask, if he has any doubt whatsoever, for the opinion of the prisoner's doctor in order that he may "give any reasons why cellular confinement is contra-indicated for medical reasons". The doctor could also be encouraged in any such report to give the governor some assistance in understanding the causes of the offending behaviour. This would be akin to the medical report process which is used by the courts and would be at the discretion of the governor and not mandatory upon the doctor. **We recommend that the Prison Rules make it clear that punishment is a governor's responsibility, not a doctor's.**

113. Suicide prevention is an important aspect of the management of the prison population. There have been two recent reports on suicide prevention in prisons, one by the Chief Inspector of Prisons[341] and one by a working group under the chairmanship of Dr Derek Chiswick, set up by the Scottish Home and Health Department.[342] Both reports underline the responsibilities of prison doctors and hospital officers in suicide prevention. The Chief Inspector stated—

> "The main responsibility for individual prevention should we think be shouldered by prison medical officers, for suicide is often bound up with mental illness, alcoholism, drug abuse and so on, and in all these areas doctors have the key role to play".[343]

He also drew attention to the need for "non-medical specialists, for example chaplains and probation staff" to pass on any information to the medical officer which suggests that an inmate may be suicidal.[344] This reinforces our view that health care in prisons, including suicide prevention, should be seen as a multi-disciplinary business.

114. The Chief Inspector of Prisons recommends that responsibility for assessing suicide risks among inmates when they are received into prison should be assigned to hospital officers who could be asked—

> "to complete a screening checklist on new inmates. This would involve ticking a number of boxes indicating evidence of, for example, mental disorder, drug abuse, alcoholism and suicide risk . . . take account of information given by the inmate himself and of the documentation accompanying him (including) any warning form supplied by the police . . . The completed checklist would then be handed by the hospital officer to the medical officer".[345]

These recommendations tie in appropriately with our recommendations about medical examination on entry to prison.

115. The report on Glenochil underlined the key role of nurse officers in the observation and management of inmates identified as suicide risks and made recommendations for greater training in psychiatric nursing for nurse officers. It

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[340] Q66.
[341] Suicide in Prisons, op cit.
[342] Report of the review of suicide precautions at HM Detention Centre and HM Young Offenders Institution, Glenochil, Scottish Home and Health Department, 1985.
[343] Suicide in Prisons, para 7.5.
[344] ibid, para 7.6; Ev p263–4, paras 17–21.
[345] ibid, para 7.7.

recommended a team approach to decision-making for those on "close special care" in the prison hospital.[346] It also drew attention to the need for a close relationship between prison staff and consultant psychiatrists called in to see individual inmates.[347] The Chief Inspector recommended that prison doctors considering treatment for an inmate assessed as a suicide risk should consider, inter alia, referral to another doctor (probably a psychiatrist) for a second opinion.[348] **We recommend that all prisoners identified as suicidal should be referred to a visiting psychiatrist for a second opinion and that the Home Office fund a research project into suicidal behaviour in prisons.**

VI CONCLUSION

116. Many of our witnesses, and particularly those who represent prisoners, have advocated the total abolition of the PMS and the transfer of responsibility for the medical care of prisoners from the Home Office to the NHS. Some argue that prisoners should be regarded in exactly the same way as any other citizen and should be able to register with a local GP and, where necessary, be referred through the GP to local NHS services. Unfortunately perhaps, we do not believe that the problem can be solved so simply. The tenor of our recommendations is that functional integration with the NHS, which, it must be stressed, is already the policy of the Home Office, should be extended. In the long run we believe that all patient care should be provided by doctors employed by the NHS. Nevertheless we believe that there will always be a need for some form of PMS, on a much smaller scale, to manage health services within the prison system and to advise the Home Office on medical matters. It is debatable whether this body should fall under the Home Office or the DHSS.

117. Prisons are the responsibility of the Home Secretary who is accountable to Parliament for the safe custody and the welfare of prisoners. It is important, for the sake of prisoners, that lines of accountability remain clear. Whatever the formal status of the PMS, the Home Office will have to be closely involved in its management and it is hard to see how responsibility for nursing services could be transferred from the Home Office and at local level from prison governors. On the other hand, there is a strong argument for greater input from the DHSS. At the moment links between the PMS and the DHSS are informal and a little ad hoc. Greater functional integration with the NHS, particularly in the field of psychiatry, will require joint planning both at national and regional level. Transferring responsibility for the PMS to the DHSS could facilitate joint planning and movement of health care staff in and out of the prison service. It might well help to dispel public suspicion that the PMS is no more than an arm of prison management.

118. In Northern Ireland prison medical services are provided on an agency basis by DHSS—doctors employed in prisons are employed by the Department of Health and Social Services for Northern Ireland.[349] Similar arrangements apply in

[346] Review of Suicide precautions at Glenochil, op cit, paras 7.6.1, 7.6.6, 7.8.1 and 7.8.2.
[347] ibid, paras 7.7.1–7.7.6.
[348] see Q531.
[349] Appendix 7.

Scotland,[350] although the position in Scotland is less clear-cut since the same department—the Scottish Home and Health Department—is responsible for the NHS and for prisons. The prison population in both those countries is however much smaller than that in England and Wales. Communication between the two responsible departments is easier on a small scale.

119. One solution which has been mooted is bringing together all forensic psychiatric services: the special hospitals, regional secure units and the prison medical service, under the auspices of DHSS. We do not find this a convincing argument. Prisoners' health needs are not limited to psychiatry. We also agree with Mr McGinnis—

> "that the secure unit service cut off from the general psychiatric service makes absolutely no sense".[351]

120. It has also been suggested that the PMS should become a special health authority, in much the same way as is planned for the Special Hospitals. This could be under the auspices of either the DHSS or the Home Office. Such an authority might include not only Home Office and DHSS representatives but outsiders, from, for example, the universities, and could allow specialist input, in, say, general medicine, community medicine and forensic psychiatry, into the planning of prison health care. This we find more plausible, although we acknowledge the difficulties in establishing such an authority. We see no intrinsic advantage at this stage in a change in the administration arrangements. We believe that the proposals we have made for improvements in the prison medical service and for closer liaison with the NHS will resolve most of the current problems. **We recommend that Ministers monitor closely progress towards integration of prison medical services with the NHS.**

121. Whether the PMS falls under the Home Office or the DHSS, it must have enough clout. The IPCS suggests that—

> "The relatively low grading levels at the higher levels of the PMS means that the service as a whole does not carry the weight that it should either in the Home Office, in the Civil Service medical hierarchy or in the NHS".[352]

The Director of Prison Medical Services is now graded at Grade 3 (Under Secretary) level, a grade below the Director General of Prison Services (Grade 2) and two below the Head of the Civil Service Medical Advisory Service (Grade 1A). The Director currently earns between £32,350 and £40,000 a year.[353] In comparison, the Medical Director of a Special Hospital receives over £46,000 exclusive of any distinction awards.[354] We understand that the grading of the top management posts in the PMS are currently under review.[355] If it is to attract candidates of high calibre and experience, the PMS must be able to offer posts of reasonable status and remuneration. **We recommend that the post of Director of Prison Medical Services be given comparability with that of Medical Director of a Special Hospital and that other management posts in the PMS be similarly upgraded.**

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[350] Appendix 5.
[351] Q1207; Ev p313, para 10.
[352] Ev p277, para 3.5.
[353] HC Deb 22 May 1986, cols 239–244*w*.
[354] Appendix 2, see Q146.
[355] Q1370.

122. The PMS must also have a clearly identified budget.[356] At present it is hard to establish how much the PMS costs as it is subsumed among various sub-heads. The Home Office estimates that medical services cost £31.8 million in 1984–85.[357] Staff costs only be identified where there are fixed complements. Excluding locums and visiting specialists, doctors' pay amounted to a little under £3 million in 1985–86. Nursing staff (nurses and hospital officers) costs were expected to be around £15.5 million. It is not, apparently, possible to identify expenditure on prison hospitals.[358] The Home Office is currently introducing a new local budgetary control system which will devolve to prison governors responsibility for the entire budget for their prison, including medical services.[359] We support the principle of devolving financial control to local level but see a danger that medical services might lose out. We have received evidence suggesting that resources allocated to health care services have been diverted to fund the construction of new prisons.[360] Lord Glenarthur assured us that there was no truth in this.[361] Dr Kilgour told us—

> "Resources will always be found for what are legitimate professional judgements of what the needs of the patient are".[362]

Nevertheless, it does seem to be easier to persuade the prison authorities to build and equip a new prison on a green field site than to provide a few more hospital officers in an inner city prison to ensure proper night-time nursing cover. The new budgetary system must ensure that prison health care is adequately funded. Some reconsideration of the proposed new arrangements may be necessary for the maintenance of standards and to fit in with the administrative structure and contractual arrangements we envisage. **We recommend that the Home Office consider before further extending the new budgetary arrangements, exactly how resources for staffing of prison hospitals and how capital work on prison hospitals will be financed and that details of such arrangements be made available to Parliament. We also recommend that expenditure on health services be separately identified.**

123. Most importantly of all the PMS must be open to public scrutiny. At present, the only formal inspection of the PMS is that carried out by HM Chief Inspector of Prisons.[363] The Inspectorate's staff includes a Specialist Inspector for medical matters and an Adviser on medical matters[364] but their input seems to be limited. During inspections, their findings are filtered through the team leader[365] and the medical section of the Inspector's Annual Report amounts to only a few paragraphs. **We recommend that the role of the medical advisers to HM Chief Inspector of Prisons be strengthened and their reports be published in full.**

124. Dr Kilgour suggested involving the various Royal Colleges in some supervisory or inspectorial role.[366] Other witnesses have advocated a role for the

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356 Q907.
357 Appendix 1, para (g).
358 Appendix 1, para h(iv); Ev p281, para 8.1.
359 Q1365–6.
360 Q1050; Ev p279, para 5,2; Ev p241, paras 3.4, 6.3.
361 Q1368.
362 Q 1367.
363 Ev p266, para 5.
364 Report of Chief Inspector, op cit, Appendix 3.
365 Dr Benjamin Lee, The Lancet, 4 June 1983, 1268–9; Ev, p134, para 21.
366 Q445.

Health Advisory Service (HAS), the Community Health Councils,[367] or, in the case of psychiatric treatment, the Mental Health Act Commission.[368] In its first Biennial Report the MHA Commission announced that it would be giving special attention to mentally disordered people in prison.[369] However to bring prison hospitals formally within the remit of the Commission might impede transfer of mentally disordered prisoners to psychiatric hospitals. In our view, any prisoners whose condition falls within the terms of the Mental Health Act ought not to be in prison at all. It might well be useful to extend the remit of the HAS to cover prisons, but if its role were to be more than nominal, it would certainly need more resources. Mr McGinnis of the DHSS told us—

> "Without a considerable increase in its complement there is no way it [the HAS] could provide a regular input to the monitoring of the services in prisons".[370]

We note that the Prison Inspectorate has been developing links with other inspectorates whose interests overlap with theirs, such as HM Inspectorate of Schools, and HM Inspectorate of Fire Services and the Health and Safety Executive.[371] This seems to be a commendable development. **We recommend that HM Chief Inspector of Prisons develop links with the Health Advisory Service.**

125. Prisoners may raise complaints about the medical care they receive in prison with the Board of Visitors of their prison establishment or with the Parliamentary Commissioner for Administration. The Ombudsman's remit is limited to administrative actions: he cannot question the clinical judgement of doctors.[372] Boards of Visitors too find it difficult, as laymen, to deal with medical problems.[373] AMBOV thought it would help them in dealing with such complaints if all Boards of Visitors had a member with medical experience and could seek a second opinion without appearing to cause offence to the prison doctor.[374] We put the first of these suggestions to Lord Glenarthur, who described it as "an interesting suggestion"[375] although he did not want to see a hard and fast rule that there should be some medically trained person on the panel. **We recommend that the Home Office seek to appoint to the Board of Visitors of each prison establishment, a person with a medical or nursing background. We further recommend that the opportunities for Boards of Visitors to seek a second medical opinion in circumstances where prisoners make allegations criticising the medical treatment they have received be extended and clarified.**

126. To be fair to the Prison Department, it has recently begun to open itself a little more to public scrutiny. During this inquiry, prison doctors were free to let us have their views and both in written evidence to us and in our discussions during our visits, they took advantage of that opportunity. Not all of what happens in prison is attractive or commendable. We hope that wider public knowledge about prisons will lead to public pressure for improvement in conditions. It might

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[367] P47; Ev p200, para 6.2; Ev p154, para 5.4.
[368] Ev p170; Q927.
[369] First Biennial Report of the Mental Health Act Commission, 1983–85, HC 586, Session 1985–86 page 56; see Ev p314, para 15.
[370] Q1241.
[371] Report of Chief Inspector, op cit, para 1.08.
[372] see Fourth Report of the PCA, 1982–83, Selected Cases 1983, Vol 2, HC 312, page 63.
[373] Ev p213; Ev p292.
[374] Qs1107–1111.
[375] Qs1260, 1261.

also help to dispel some of the exaggerated beliefs in the inadequacy of the prison medical service.

127. Many of our recommendations will have implications for the Prison Rules and Prison Standing Orders governing the work of medical officers and hospital officers. These include our recommendations about medical examination on entry to prison, medical records, punishment, suicide prevention, the contracts of visiting general practitioners and visiting consultants, and environmental health. **We recommend a thorough review by the Home Office of the Prison Rules and of the Standing Orders relating to medical treatment of prisoners and the responsibilities of doctors.**

128. One anomaly in the Prison Rules is worthy of comment. A remand prisoner is entitled, at his own expense, to seek a second medical opinion. A convicted prisoner is not so entitled, and the seeking of a second medical opinion is at the discretion of the prison medical officer. This was drawn to our attention by a number of witnesses[376] in relation to certificates of fitness for adjudication and a prisoner's fitness to undergo prolonged periods of cellular confinement. In the Netherlands, all prisoners have a right to seek a second medical opinion, although that right is rarely exercised. We cannot see a justification for maintaining a distinction between remanded and convicted prisoners in relation to obtaining a second medical opinion, and **we recommend that Prison Rule 17 be amended to permit a second medical opinion to be sought, in relation either to a medical diagnosis or in relation to fitness for cellular confinement, by any prisoner, even where the medical officer does not so recommend.** We believe that even if this right is rarely used, this would be a step towards increasing prisoners' confidence in the medical treatment they receive.

129. We believe that our recommendations taken together can transform the Prison Medical Service into a prisoners' health service, less doctor-dominated, more professional, primarily concerned with the delivery of multi-disciplinary health care and in good working contact with the NHS, universities and the probation service. At the beginning of our inquiry the Director of Prison Medical Services told us that there was "considerable scope for improvement".[377] We look to the Government to take urgent steps to bring health services for prisoners up to date.

[376] eg Q819, Qs823–834; Qs930–3; Qs1106–7.
[377] Q1.

LIST OF RECOMMENDATIONS

1. We recommend that, in its current inquiry into the prison system, the Home Affairs Committee examine the effect of the sentencing and remand practices of the courts on the size and nature of the prison population; the practice of locking prisoners in their cells all day; opportunities for work and regular exercise; access to satisfactory lavatory and washing facilities and the number and availability of prison staff. (para 15)

2. We recommend that the Home Office consider alternatives to the routine medical examination of all prisoners on reception into custody, including screening by a qualified nurse. (para 17)

3. We recommend that doctors be given discretion to allow prisoners to keep in their cells limited quantities of simple drugs or medicaments. (para 19)

4. We recommend that in all circumstances any prisoner asking to see a doctor should be able to do so, and that such requests should be facilitated by prison officers. (para 20)

5. We recommend that the Home Office take immediate steps to ensure that patients in prison hospitals have access to proper lavatory and washing facilities at all times. (para 22)

6. We recommend that the Home Office acknowledge the difference between sick-bays and hospitals; decide which prison establishments require more elaborate hospitals and staff them accordingly; and take steps to ensure that there is 24 hour on-called nursing cover in all prison establishments. (para 23)

7. We recommend that the surgical units at Wormwood Scrubs and Parkhurst be modernised as soon as possible. (para 27)

8. We recommend that X-rays be taken only by qualified radiographers in approved conditions. (para 28)

9. We recommend that EEG equipment should only be used by staff properly trained, to NHS standards, in their use. (para 29)

10. We recommend that the Prison Department review the number of prison pharmacists and pharmacy technicians and consider whether it would be cost-effective to employ pharmacists on a sessional basis and to use NHS ordering and supplying arrangements. (para 32)

11. We recommend that immediate steps be taken to devise a single form of medical record, capable of holding all case papers, for all prisoners. (para 34)

12. We recommend that immediate steps be taken to devise and bring into use medical records suitable for the recording of women's medical state. (para 35)

13. We recommend that the medical records on prisoners be kept in the prison hospital under the auspices of medical staff, not in the main prison record. (para 36)

14. We recommend that urgent steps be taken to centralise, possibly on computer, prisoners' medical records, and to devise a system whereby records can speedily be transferred from prison to prison and be retrieved when a person is reconvicted and enters prison again. (para 37)

15. We recommend that prison doctors make greater effort to communicate to a prisoner's GP details of treatment given in prison and respond helpfully to any request from a GP for such information. (para 39)

16. We recommend that the Prison Department examine carefully the points raised by the Prison Governors' Branch of the SCPS regarding the provision of chiropody services and make it the practice to recruit chiropodists on a sessional basis. (para 40)

17. We recommend that the Home Office establish better domestic environments for women offenders with young children; and that the Parole Board treat pregnant women and women with young children more sympathetically when considering applications for parole. (para 44)

18. We recommend that the Home Office extend its research into the health of babies born to mothers in prison to cover the antenatal and maternity care offered to women prisoners. (para 47)

19. We recommend that the Government remove responsibility for hygiene in prisons from prison medical officers and crown immunity from prison kitchens and hospitals. We further recommend that the role of Regional and District Medical Officers be extended to enable them, as specialists in community medicine, to play a part in the maintenance of environmental health in prisons. (para 49)

20. We recommed that the Home Office, in close consultation with the DHSS, reconsider whether the present plans for developing isolation facilities for prisoners with AIDS are appropriate. (para 51)

21. We recommend that additional resources be made available to establish a comprehensive health education programme for prisoners and staff throughout the prison system. (para 54)

22. We recommend that the Home Office set a date by which all psychiatric reports prepared for the courts, or for the Parole Board, will be by doctors with recognised training and qualifications in psychiatry. (para 55)

23. We recommend that magistrates and judges make more use of the alternatives to imprisonment for an accused person needing psychiatric reports. (para 56)

24. We recommend that the interaction of the provisions of Section 35 and Section 36 of the Mental Health Act be re-examined in order to allow the two functions of remand to hospital for report or treatment, to operate simultaneously. (para 57)

25. We recommend that the Government recognise the key role in the psychiatric assessment of offenders which could be played by Regional Secure Units and reconsider urgently the number of planned places in secure units. (para 59)

26. We recommend that the Home Office, in consultation with the DHSS, take steps to provide, as soon as is practicable, for all psychiatric reports required by courts to be prepared by consultants with control of appropriate NHS facilities. (para 61)

27. We recommend that immediate steps be taken to find hospital places for those prisoners whose mental illness or severe mental impairment fall within the terms of the Mental Health Act. (para 64)

28. We recommend the establishment of a number of pilot units for violently disruptive prisoners and a study into the characteristics of these inmates and the effect of different forms of management and treatment. (para 67)

29. We recommend that the purpose of specialist psychiatric units within prisons be carefully defined before they are established, and their role limited to ensure that those patients who ought to be in hospital are not kept in prison. (para 68)

30. We recommend that the Home Office give the highest priority to building the new unit to replace Holloway's C1 Wing. (para 71)

31. We recommend that the Government implement the recommendations contained in the Report of the Advisory Committee on the Therapeutic Regime at Grendon, to provide an acute psychiatric unit and a women's wing, reduce the number of prisoners and ensure that funding and manpower is sufficient to maintain Grendon's special regime. (para 72)

32. We recommend that the Government, in conjunction with voluntary organisations, health authorities and local authority social services departments, give urgent priority to providing a suitable range of hostel and sheltered accommodation and help for people no longer capable of helping themselves. (para 74)

33. We recommend that the Home Office take steps to improve liaison at a local level between prisons and drug and alcohol rehabilitation projects; extend the use of parole for drug and alcohol abusers on condition of attendance at a specialist facility; consider establishing pre-release hostels at selected prisons; and initiate a national study into the prevalence of drug and alcohol addiction within the prison population and its relationship to crime. (para 81)

34. We recommend that consideration be given to introducing a procedure whereby a prisoner records his consent in writing to the administration of psychotropic medication. (para 83)

35. We recommend that the Prison Department stop publishing statistics on prescribing by prison doctors. (para 85)

36. We recommend the speedy introduction of a unified nursing service. (para 90)

37. We recommend that the Home Office examine the arrangements made for nurse officer training in the Scottish prison service. (para 93)

38. We recommend a review of the nursing needs of all prison hospitals and a comprehensive policy towards the level and type of nursing service needed in prison establishments. (para 94)

39. We recommend that the post of Chief Nursing Officer be revived, with responsibility for an integrated service of nurses and hospital officers, and that nursing services be accorded equal status with medical services within the prison service. (para 95)

40. We recommend that the Home Office give priority to meeting the need for clinical psychologists within the prison service, and to facilitating close liaison between medical and psychological services. (para 96)

41. We recommend that doctors working in the Prison Service be encouraged to undertake "medical audit" and that the Home Office sponsor a national survey into the general health needs of prison inmates. (para 99)

42. We recommend that steps be taken to replace the present individual contracts with local general practitioners with contracts with Family Practitioner Committees. (para 100)

43. We recommend that the title of "part-time medical officer" be abandoned and that general practitioners working in prisons be known simply as doctors. (para 101)

44. We recommend that "functional integration" be taken a stage further by replacing the present haphazard arrangements with individual specialists, by a system of contracts with Regional Health Authorities to provide a specified number of sessions in each prison. (para 102)

45. We recommend that eventually every prison doctor should work at least one day a week outside the prison setting. (para 105)

46. We recommend that prison doctors immediately be given a reasonable "on-call" allowance in recognition of the extra hours they are expected to work beyond their contracted week. (para 106)

47. We recommend that prison doctors be employed on the same contractual basis as NHS doctors. (para 107)

48. We recommend that provision be made in prisons for training grades, probably on a part-time basis, as well as consultant appointments. In addition we recommend that some prison appointments either in general practice or in psychiatry be linked to appropriate university departments. (para 108)

49. We recommend that the Prison Rules make it clear that punishment is a governor's responsibility, not a doctor's. (para 112)

50. We recommend that all prisoners identified as suicidal should be referred to a visiting psychiatrist for a second opinion and that the Home Office fund a research project into suicidal behaviour in prisons. (para 115)

51. We recommend that Ministers monitor closely progress towards integration of prison medical services with the NHS. (para 120)

52. We recommend that the post of Director of Prison Medical Services be given comparability with that of Medical Director of a Special Hospital and that other management posts in the PMS be similarly upgraded. (para 121)

53. We recommend that the Home Office consider before further extending the new budgetary arrangements, exactly how resources for staffing of prison hospitals and how capital work on prison hospitals will be financed and that details of such arrangements be made available to Parliament. We also recommend that expenditure on health services be separately identified. (para 122)

54. We recommend that the role of the medical advisers to HM Chief Inspector of Prisons be strengthened and their reports be published in full. (para 123)

55. We recommend that HM Chief Inspector of Prisons develop links with the Health Advisory Service. (para 124)

56. We recommend that the Home Office seek to appoint to the Board of Visitors of each prison establishment, a person with a medical or nursing background. We further recommend that the opportunities for Boards of Visitors to seek a second medical opinion in circumstances where prisoners make allegations criticising the medical treatment they have received be extended and clarified. (para 125)

57. We recommend a thorough review by the Home Office of the Prison Rules and of the Standing Orders relating to medical treatment of prisoners and the responsibilities of doctors. (para 127)

58. We recommend that Prison Rule 17 be amended to permit a second medical opinion to be sought, in relation either to a medical diagnosis or in relation to fitness for cellular confinement, by any prisoner, even where the medical officer does not so recommend. (para 128)

ANNEX 1

LIST OF WRITTEN EVIDENCE WHICH HAS NOT BEEN PRINTED

The following memoranda have been reported to the House, but to save printing costs they have not been printed and copies have been placed in the House of Commons Library where they may be inspected by Members. Other copies are in the Record Office, House of Lords, and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1 (tel. 01–219–3074). Hours of inspection are from 9.30 am to 5.00 pm on Mondays to Fridays).

P5	Memorandum by R J Kendrick, Director of Operations, Northern Ireland Prison Service
P6	Memorandum by the Faculty of Occupational Medicine, Royal College of Physicians
P7	Memorandum by Denis Rice
P8	Memorandum by Dr Janet Parrott
P9	Memorandum by Dr Benjamin Lee
P10	Memorandum by the Regional Standing Working Group on Forensic Psychiatry, South East Thames RHA
P11	Memorandum by Tony Lloyd MP
P12	Memorandum by Dr G Pollitt, Principal Medical Officer, Wakefield
P15	Memorandum by Dr Lawson, Senior Medical Officer, Risley
P16	Memorandum by Audrey Peckham
P19	Memorandum by Women in Prison
P22	Memorandum by the British Psychological Society
P23 & 23A	Memoranda by the Health Visitors Association
P28	Memorandum by the College of Radiographers
P31	Memorandum by the Royal College of Physicians (Faculty of Community Medicine)
P33	Memorandum by MENCAP
P36	Memorandum by the British Paediatric Association
P37A	Memorandum by Dr B D Cooper, Principal Medical Officer, Parkhurst
P37B	Memorandum by Dr L P McErlean, Medical Officer, Kingston
P37C	Memorandum on Camp Hill Prison
P39	Memorandum by Dr H E Godfrey, Medical Officer, Styal Prison
P40	Memorandum by the Association of Nurse Administrators
P42	Memorandum by Dr M K Hare
P43	Memorandum by Dr R W K Reeves, Consultant Psychiatrist, Glenside Hospital, Bristol
P44	Memorandum by the Chairman of the Board of Visitors, HM Prison Canterbury
P45	Summary of evidence from former prisoners
P45A	Memorandum by Ms Sear and Ms Tansy
P46	Memorandum by Civil Service Medical Advisory Board
P47	Memorandum by Tony Smythe, Director of the Association of Community Health Councils in England and Wales
P48	Memorandum by Ronald Strank, former Chief Nursing Officer, PMS

P49	Memorandum by Dr David C Manson
P50	Memorandum by Vere Fletcher
P51	Memorandum by Black Community Groups
P52	Memorandum by DHSS
P56	Notes on HM Prison Liverpool
P57	Note by DHSS on Broadmoor
P59	Memorandum by Rev G L W Armstrong et al, Parkhurst Prison
P60	Memorandum by the Association of Prison Dental Surgeons in the UK
P61	Memorandum by the British Dental Association
P63	Note on Medical Services at Leeds by the PMO
P65	Note to Roy Galley MP from a constituent on Preston Prison
P66	Memorandum by Dr Bradley, SMO at Wakefield
P66A & 66A1	Memorandum by Mr N'Jie and Mr Vickers
P66B	Memorandum by Mr Clark, HO at Wakefield
P66C	Letters from visiting consultants at Wakefield
P67A	Note by Dr John Taylor, Friern Hospital
P69A	Supplementary memorandum by the National Association of Probation Officers
P71	Memorandum by Mr M Stokes, Hospital Officer, Wakefield Prison
P77	Letter from Lord Glenarthur to Tom Cox MP
P79	Memorandum by South of England Forensic Social Work Group
P82 & P82A	Memoranda by the Society of Clinical Psychiatrists
P83 A-D	Memoranda by Professor J Bernheim, Institut Universitaire de Medicine Legale, Geneva
P84	Memorandum by Mick Thynne, HM Prison, Lewes
P85	Memorandum by Dr D Somekh, Cane Hill Hospital
P87	Memorandum by Douglas Hoyle MP
P89	Memorandum by Dr P G Woolf
P90	Papers on Medical Care in Dutch and Swedish Penal Institutions
P91	Memorandum by the Parliamentary Mental Health Group
P92	Memorandum by the National Schizophrenia Fellowship
P97	Memorandum by Charles Irving MP
P98	Memorandum by B R Godfrey, HM Prison Highpoint
P102	Memorandum by Dr A S Horne, Regional Forensic Service, Manchester

ANNEX 2

ESTABLISHMENTS VISITED DURING INQUIRY

Aylesbury Youth Custody Centre
Bedford Prison
Birmingham Prison (Winson Green)
Brixton Prison
Camp Hill Prison
Featherstone Prison
Grendon Prison
Holloway Prison
Kingston Prison
Liverpool Prison (Walton)
Manchester Prison (Strangeways)
Parkhurst Prison
Risley Remand Centre
Styal Prison
Winchester Prison

Northern Ireland
Belfast Prison
Maze Prison

Scotland
Barlinnie Prison (Glasgow)
Saughton Prison (Edinburgh)

Special Hospital
Broadmoor

Regional Secure Unit
Denis Hill Unit, Bethlem Royal Hospital

ANNEX 3

VISIT TO SWEDEN AND THE NETHERLANDS

1. During its inquiry into the Prison Medical Service, the Committee visited Sweden and the Netherlands to examine how health care was provided in prisons in those countries and how mentally disordered offenders were treated.

SWEDEN 23–30 APRIL 1986

2. The Committee began its visit with a morning in the Riksdag in Stockholm and a meeting with members of the Justice and Social Affairs Committees. In the afternoon the Committee had a meeting with the Minister of Health and Social Affairs.

3. The Committee travelled to Norrköping for a discussion with officials of the National Prison and Probation Administration. Members were told that medical care in prisons was based on the principle of "normalisation": prisoners had the same right to medical care as anyone else. It was difficult to recruit doctors to work in prisons and where posts had not been filled the money had been spent on extra nurses. Most doctors were employed on a consultancy basis, for perhaps 4 hours a week, but 3 were employed full-time. Cooperation with hospitals outside was good for somatic cases but there were problems in psychiatry. It was not always easy to get hospitals to accept difficult prisoners. There were 65 places in psychiatric units within the prison system. There were also 3 Special Psychiatric Hospitals in the community. Public concern about the level of prescribing of tranquillisers in prisons had led to the publication of computerised data of each doctor's prescribing practice. Prescription of psychotropic drugs in prisons had fallen dramatically in recent years.

4. The Committee visited two prisons during its visit to Sweden: Hinseberg Prison, near Örebro, and Österåker, near Åkersberga. In both prisons conditions were good and, within a secure perimeter, prisoners had considerable freedom of movement. All prisoners were expected to work or study a 40 hour week. Both prisons had units where families could occasionally stay for the weekend. Hinseberg was a closed institution for women. It had 94 places and the great majority of its inmates were drug or alcohol abusers. Urine testing was regularly used and the prison was drug free. Some prisoners were involved in a special contract system, agreeing not to take drugs and to participate in a treatment programme in return for privileges. Medical care was overseen by a doctor living

60 miles away who visited only fortnightly. There were 2 full-time nurses and a psychiatrist visited once a week. Where necessary women used outside hospital facilities. Österåker was a closed prison for 170 men, sentenced to over 2 years' imprisonment. It contained a psychiatric unit for disturbed prisoners and a unit for 65 drug abusers on a contract system similar to that at Hinseberg. All new arrivals were blood tested for AIDS. There were 3 full-time female nurses, a nursing auxiliary and 2 full-time psychologists. The prison doctor visited only fortnightly but a psychiatrist worked 30 hours a week at the prison. Österåker also contained a remand wing for men and women. There conditions were less impressive and half of the prisoners were kept in isolation on the instruction of the prosecution.

5. The Committee's final day in Sweden was spent in Uppsala, at the clinic of Psychiatric Forensic Medicine. This was one of four clinics run by the Ministry of Health for the assessment of mentally disordered offenders. Some 3,500 offenders a year were given a preliminary psychiatric examination by order of the court. About 600 of these were sent on to a forensic clinic for full examination over a 4–6 week period. The Uppsala clinic had 25 places, for men and women. Assessment was carried out by a multi-disciplinary team and their reports, which included both diagnosis and recommendations for treatment, were nearly always accepted by the courts.

THE NETHERLANDS 30 APRIL—2 MAY 1986

6. During its brief visit to the Netherlands, the Committee was particularly interested in the Dutch system of TBR, a form of detention for offenders with diminished responsibility. In Dutch law an offender might be judged to be partially responsible for his crime and might be required to spend part of his sentence in prison and part in a TBR clinic for treatment. There were now 430 patients including 20 women, in TBR clinics and the average stay was $4\frac{1}{2}$ years. Increasingly, TBR clinics were taking TBR prisoners immediately after sentence and ordinary prisoners who became ill in prison.

7. The Committee travelled to Groningen to visit the Dr S van Mesdagkliniek, the most secure of the TBR clinics. The clinic had places for 65 male patients, nearly all of whom had committed violent crimes. The unit had only 4 nurses: most of the day-to-day patient care was undertaken by trained social work assistants. Perimeter security was very tight but inside patients were free to move around. They were allowed occasional overnight visits. Some Members made a brief visit to the Groningen House of Detention, a remand prison for 90 men with a 10-place women's section, which took remand and short-term sentenced prisoners. The prison was built in the last century but conditions were good. Each prisoner had a single cell with a WC and basin.

8. The Committee spent a morning in Utrecht with some Members visiting the van der Hoeven Kliniek and others the Pieter Baan Centrum. The van der Hoeven Kliniek was a TBR clinic for 73 patients, of whom 7 were female. Nearly all were personality disordered and had been convicted of violent offences. The staff/patient ratio was two to one and half the staff were women. The Pieter Baan Centrum was a 36-bed psychiatric observation clinic which took male and female remand prisoners for assessment at the request of the courts. It also took a few sentenced

prisoners. Assessment was done by multi-disciplinary teams over a 7 week period. The clinic recommended TBR for about a third of its patients, and the courts nearly always accepted its advice.

9. The Committee spent the final afternoon of its visit in Amsterdam in the Over-Amstel Prison Complex which consists of six prefabricated tower blocks run as separate establishments. One group visited the Remand Prison Demersluis, the other the Remand Prison Het Veer. Demersluis ran a special programme for drug abusers, who represented 40 per cent of Over-Amstel's annual receptions. Het Veer had a unit for mentally disordered prisoners who were considered too dangerous to be sent to hospital.

10. Written material received in the course of the visit can be made available to those interested, on application to the Clerk to the Committee.

MINUTES OF THE PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT

WEDNESDAY 25 JUNE 1986

Members present:

Mrs Renée Short, in the Chair

Mr Tony Favell
Mr Roy Galley
Mr Ron Lewis
Mr Terry Patchett
Mr John Powley
Sir David Price
Mr Nicholas Winterton

The Committee deliberated.

Draft Report on the Prison Medical Service proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 7 read and agreed to.

Paragraph 8 read, amended and agreed to.

Paragraph 9 read, amended and agreed to.

Paragraphs 10 to 14 read, and agreed to.

Paragraph 15 read, amended and agreed to.

Paragraphs 16 to 21 read and agreed to.

Paragraph 22 read, amended and agreed to.

Paragraphs 23 to 28 read and agreed to.

Paragraph 29 read, amended and agreed to.

Paragraphs 30 to 39 read and agreed to.

Paragraph 40 read, amended and agreed to.

Paragraphs 41 to 46 read and agreed to.

Paragraph 47 read, amended and agreed to.

Paragraphs 48 to 50 read and agreed to.

Paragraph 51 read, amended and agreed to.

Paragraphs 52 to 54 read and agreed to.

Paragraph 55 read, amended and agreed to.

Paragraph 56 read and agreed to.

Paragraph 57 read, amended and agreed to.

Paragraphs 58 to 66 read and agreed to.

Paragraph 67 read, amended and agreed to.

Paragraph 68 read, amended and agreed to.

Paragraphs 69 to 71 read and agreed to.

Paragraph 72 read, amended and agreed to.

Paragraph 73 read and agreed to.

Paragraph 74 read, amended and agreed to.

Paragraph 75 read and agreed to.

Paragraph 76 read, amended and agreed to.

Paragraphs 77 to 79 read and agreed to.

Paragraph 80 read, amended and agreed to.

Paragraph 81 read, amended and agreed to.

Paragraph 82 read and agreed to.
Paragraph 83 read, amended and agreed to.
Paragraph 84 read and agreed to.
Paragraph 85 read, amended and agreed to.
Paragraphs 86 to 89 read and agreed to.
Paragraph 90 read, amended and agreed to.
Paragraphs 91 and 92 read and agreed to.
Paragraph 93 read, amended and agreed to.
Paragraphs 94 to 104 read and agreed to.
Paragraph 105 read, amended and agreed to.
Paragraphs 106 and 107 read and agreed to.
Paragraph 108 read, amended and agreed to.
Paragraph 109 read and agreed to.
Paragraph 110 read, amended and agreed to.
Paragraph 111 read and agreed to (now in Paragraph 110).
Paragraph 112 (now Paragraph 111) read and agreed to.
Paragraph 113 (now Paragraph 112) read, amended and agreed to.
Paragraphs 114 and 115 (now Paragraphs 113 and 114) read and agreed to.
Paragraph 116 (now Paragraph 117) read, amended and agreed to.
Paragraphs 117 and 118 postponed.
Paragraphs 119 to 122 (now Paragraphs 116 to 119) read and agreed to.
Paragraph 123 (now Paragraph 120) read, amended and agreed to.
Paragraphs 124 and 125 (now Paragraphs 121 and 122) read and agreed to.
Paragraph 126 (now Paragraphs 123 and 124) read, amended and agreed to.
Paragraph 127 (now in Paragraph 124) read, amended and agreed to.
Paragraph 128 (now Paragraph 125) read, amended and agreed to.
Paragraph 129 (now Paragraph 126) read, amended and agreed to.
Postponed paragraphs 117 and 118 (now Paragraphs 127 and 128) read and agreed to.
Paragraph 130 (now Paragraph 129) read and agreed to.
Several papers were ordered to be annexed to the Report.
Resolved, That the Report be the Third Report of the Committee to the House.
Ordered, That the Chairman do make the Report to the House.
Ordered, That the provisions of Standing Order No 92 (Select Committees (reports)) be applied to the Report.
Several papers were ordered to be appended to the Minutes of Evidence.
Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.
Several memoranda were ordered to lie upon the Table.
Ordered, That the provisions of Standing Order No 93 be applied to the memoranda.
[Adjourned till Wednesday next at Four o'clock.

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HOUSE OF COMMONS

Third Report from the

SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

Volume II

Minutes of Evidence and Appendices

Ordered by The House of Commons *to be printed*
25 June 1986

LONDON
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The Social Services Committee is appointed under SO No 99 to examine th expenditure, administration and policy of the Department of Health and Socia Security, associated public bodies, and similar matters within the responsibilitie of the Secretary of State for Northern Ireland.

The Committee consists of a maximum of eleven members, of whom th quorum is three.

The Committee shall have power—

(a) to send for persons, papers and records, to sit notwithstanding an adjournment of the House, to adjourn from place to place, and to repor from time to time;

(b) to appoint persons with technical knowledge either to supply informatio which is not readily available or to elucidate matters of complexity withi the Committee's order of reference;

(c) to communicate to any other such committee its evidence and any othe documents relating to matters of common interest; and

(d) to meet concurrently with any other such committee for the purposes o deliberating, taking evidence, or considering draft reports.

Unless the House otherwise orders, all Members nominated to the Committe continue to be members of the Committee for the remainder of the Parliament

WEDNESDAY 14 DECEMBER 1983

The following were nominated as members of the Committee:

Mr James Couchman
Mr David Crouch
Mrs Edwina Currie
Mr Roy Galley
Mr Ron Lewis
Mr Tony Lloyd
Mr Michael Meadowcroft
Sir David Price
Mrs Renée Short
Rev Martin Smyth
Mr Nicholas Winterton

Mrs Renée Short was elected Chairman on Tuesday 20 December 1983

Changes in Committee membership:

Session 1984–85

Friday 16 November 1984

Mr David Crouch *discharged.* Mr Steve Norris *added.*

Thursday 18 April 1985

Mr James Couchman and Mr Tony Lloyd *discharged.* Mr Tony Favell and M Terry Patchett *added.*

The cost of printing and publishing this volume is estimated by Her Majesty's Stationer Office at £9648.

ssion 1985–86

iday 6 December 1985

r Steve Norris and Mr Michael Meadowcroft *discharged.* Mr Charles Kennedy d Mr Tim Yeo *added.*

uesday 17 December 1985

ev Martin Smyth *resigned.*

uesday 8 April 1986

rs Edwina Currie *discharged.* Mr John Powley *added.*

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HOUSE OF COMMONS

SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

Wednesday 20 November 1985

Prison Medical Service

Dr John L Kilgour and Mr Peter Barker, BEM

Ordered by The House of Commons *to be printed*
20 November 1985

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MINUTES OF EVIDENCE TAKEN BEFORE THE SOCIAL SERVICES COMMITTEE

WEDNESDAY 20 NOVEMBER 1985

Members present:

Mrs Renée Short, in the Chair

Mr Tony Favell
Mr Roy Galley
Mr Ron Lewis
Rev Martin Smyth
Mr Nicholas Winterton

Memorandum submitted by the Home Office

RODUCTION

Statutory recognition of the need for medical facilities to be provided in prisons in gland and Wales dates from 1774. The present day Prison Medical Service is responsible the health care of about 43,500 inmates in 116 establishments in England and Wales.[1]

EDICAL DIRECTORATE

The Director of Prison Medical Services, based in Prison Department Headquarters in ndon, is responsible for clinical aspects of medical policy, recruitment and training ndards and the effectiveness and efficiency of prison medical services. The Director is countable to the Director-General of the Prison Service and is a member of the Prisons ard. He is supported by a Deputy Director of Principal Medical Officer rank and three ler Principal Medical Officers part of whose duties are to supervise the medical services each of four regions. His staff also includes a Head of Nursing Services and a Head armacist.

The Medical Directorate has 2 main purposes:

a) Managerial—to organise and manage prison medical services and to direct and support field staff on all professional matters;
b) Advisory—to advise Home Office Ministers, the Director-General of the Prison Service and other officials on medical policy generally and medical matters relating to individual inmates.

SPITAL FACILITIES

Every establishment has its own 'hospital' which provides facilities for the treatment of ambulant sick and for the routine treatment of bed patients who do not require detailed estigation or extremely skilled nursing. More elaborate facilities are generally available the larger establishments, to which inmates may be transferred as necessary. For mple, there are fully equipped surgical theatres at Liverpool and Parkhurst. In 1983 re were 41,524 admissions to prison hospitals and the average daily number of patients these hospitals was 1,319.

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[1] 46,700 in May 1985.

The cost of printing and publishing these Minutes of Evidence is estimated by Her Majesty's Stationery ice at £2,268.

Medical Officers

Each establishment in the field has either a full-time managing medical officer (who ma be a basic grade medical officer, a Senior Medical Officer or a Principal Medical Officer) c a part-time medical officer who will usually be a local General Practitioner contracted t devote a minimum number of hours each week to prison duties. The present authorise strength of medical staff working in establishments is 4 Principal Medical Officers (PMOs 26 Senior Medical Officers (SMOs), 68 full-time Medical Officers and 117 part-tim Medical Officers. Currently there are vacancies for 7 full-time and 16 part-time medica officers. These gaps are covered by locum appointments.

At the larger establishments there are one or more full-time medical officers ofte assisted by a part-time medical officer; at the smallest establishments a part-time medica officer works single handed, usually with locum support from colleagues in his genera practice. As well as undertaking duties in their own establishments PMOs and SMO usually act in an advisory capacity towards a small group of neighbouring establishment

Visiting Practitioners

Additional medical, and paramedical, support is provided by Visiting Practitioners in variety of specialities over 120 of whom are employed on a sessional basis. In 1983, 98,15 inmates were referred to Visiting Specialists and Consultants.

Other Hospital Staff

Medical Officers in establishments for males are assisted by hospital officers. These ar uniformed prison officers who have received training designed to equip them to undertak basic nursing. There are 5 ranks of hospital officer corresponding to the prison office ranks. On 31 December 1984 there were 1,018 authorised posts of which 158 were vacant Nearly 100* hospital officers hold nursing qualifications and a programme is under way t increase the number by recruitment of male nurses to train as hospital officers.

Nurses are also employed, mainly in the establishments for women and girls and in th surgical units. On 31 December 1984 there were 193 authorised nurse posts of which 4 were vacant.

Pharmacists are employed in some establishments. Between them they organise an supervise pharmaceutical and dispensing services throughout the system. They are assiste by 8 pharmacy technicians. In the small establishments a dispensing service is provided b specially trained hospital officers under the direction of one of the supervising pharmacists

Functions of the Prison Medical Service

The Prison Act 1952 requires that every prison shall have a medical officer, and th Prison Rules 1964 made under the Act placed on the medical officer responsibility for car of the health, mental and physical, of prisoners in the establishment to which he i appointed. The tasks of medical officers and their supporting staff are summarised in th following paragraphs.

Care of the Physically Ill

This involves the examination of all inmates on reception and discharge, the examination of inmates who report sick and the treatment in or out of 'hospital' of those who require treatment.

Health, Preventive Medicine and Health Promotion, Hygiene and Advice to Management

The medical officer is expected to advise on all matters affecting the health and hygiene of his establishment, including living and working conditions, sanitation, ventilation working arrangements, diet and clothing, and the maintenance and promotion of health o

*131 in November 1985.

e inmates. He has important responsibilities in relation to inmates who are subject to ciplinary proceedings and inmates undergoing punishment, or subject to restraint, or tricted association. He also has important liaison responsibilties with the NHS, rticularly the Environmental Health Service.

ports to Court, the Home Office and the Parole Board

The work of preparing reports for the courts occupies a great deal of time of medical icers at local prisons and remand centres, who are expected not only to prepare court ports in those cases where the court has asked for a medical report but also to anticipate e needs of the court by supplying a pre-trial report in any case where the defendant's edical condition may be relevant to the sentence which the court may impose. Other ports include those for the Category A Committee, Local Review Committees and the role Board in connection with parole and other release procedures and for Prison epartment Headquarters or Regional Officers about the allocation or management of rticular prisoners.

ychiatric Work

Psychiatric assessment is an essential element of the report writing mentioned in the eceding paragraph. In addition there is the continuing need for diagnosis and assessment fecting the consideration of whether an inmate should be transferred to a psychiatric spital under the provisions of the Mental Health Act 1983. Many inmates show some ental abnormality which is not such as to justify transfer to hospital, and such people are ated in prison. Visiting Psychiatric Consultants play an important part in this treatment. roup psychotherapy is provided at the psychiatric prison at Grendon and at some other ablishments.

LATIONS WITH THE NATIONAL HEALTH SERVICE

The facilities which the Prison Medical Service does not itself provide are supplied by the tional Health Service. It is estimated that about $\frac{2}{3}$ of all the medical work in Prison epartment establishments is carried out by doctors whose principal employment is in the HS. The full range of facilities provided by NHS hospitals and clinics is available for the vestigation and treatment of inmates on an out-patient basis. Those suffering from severe ness which requires in-patient treatment may be transferred to NHS hospitals under tion 22(2)(b) of the Prisons Act 1952. Dental work is carried out by Visiting Dentists der the NHS, for which most establishments have a fully equipped dental surgery in the son hospital. Similar arrangements are made with Visiting Opticians for the provision of ectacles for those who need them. Although spectacles are no longer available to inmates der the NHS the Department makes a financial contribution sufficient to cover the cost spectacles available at the lower end of the private market. Inmates wishing to have more pensive spectacles may, if they wish to do so, meet the extra cost from their private cash earnings.

Memorandum submitted by the Head of Prison Nursing Services on behalf of Senior Nurse Managers in the Prison Medical Service

E ROLE OF THE PRISON MEDICAL SERVICE

1. The prison service as a whole might be said to be uncertain of its own raison d'être. is uncertainty spreads too to the Prison Medical Service. Clearly, its basic function nains that of the medical care and treatment of inmates, but does it perform this task as a rtial service which supplements the National Health Service, being dependent on their ilities and resources, or is it a complete and independent service in its own right? Almost tainly the former.

2. Certainly, relations with the National Health Service are close and complex, and if the son Medical Service makes use of the resources of the National Health Service, the erse is also true. For example, consultants make use of prisons for forensic training in

psychiatry, thereby obtaining expertise for the registrars in training that they are unable to gain elsewhere. Also, nurses come into prisons as part of their training for the English National Board Qualification in Principles of Psychiatric Care in Secure Environments. Again, prisons provide the most suitable environment in which to acquire such training.

3. The implications of this are that there is a specialism which constitutes prison nursing. Whether or not the groups which tend to become prison inmates pose their own particular problems—one thinks here of inadequates, and in particular of certain types of mentally abnormal offenders—the fact of nursing them in a secure environment entails special conditions that do not prevail elsewhere. It is highly desirable that this special expertise be recognized in professional qualifications, which would serve the double function of furthering a sense of esprit de corps in the prison medical service as a whole, and encouraging the development of that expertise in a greater sense of professionalism. For this purpose, a basic foundation course containing this specialism recognized by the UKCC is necessary.

Mentally Abnormal Offenders

4. It has always been the case that a certain number of severely mentally disturbed offenders have been received in prisons. Many of the most acute cases will be transferred under the Mental Health Act to special hospitals or regional secure units. The decisions, however, are frequently made by hard-pressed consultants on comparatively little evidence, and often without conferring with prison medical and nursing staff who will have had considerable experience of the individual concerned. This element of arbitrariness means, in effect, that some severely disturbed offenders remain unnecessarily in prison resulting in a possible deterioration in their condition. This undesirable situation could to some degree be obviated by the formation of a co-ordinating body which would monitor the placement of inmates under the Mental Health Act.

5. There will remain nonetheless a number of mentally abnormal offenders who will in any case slip through the net of the Mental Health Act. These are characteristically trivial offenders, disturbed rather than mad, and it is in the treatment of this group, prominent in prison life, that the Prison Medical Service acquires an essential element of its expertise. It may be that prison is not the most desirable environment for such individuals, but in fact, it is frequently the only asylum available, and certainly it is the prison service which has acquired by far the greatest experience in their care and treatment.

Regionalization of Resources

6. Prison hospitals vary greatly in their size and effectiveness: some are large and wasteful of staff resources, others are cramped and overcrowded. It is felt, in the interests of efficiency and cost-effectiveness, that ideally the hospital within the prison should be sufficient to care for the casual sick only, but that regional resources, should be available to care for the seriously ill, whether mental or physical, in a non-prison enviroment.

7. It could be objected that such regional resources would become in themselves no more than substitute prisons, that the costs of transportion of prisoners would be excessive, and that they would serve merely to duplicate NHS facilities. None of these objections hold water. Provided that these regional hospitals have a secure perimeter, patients can be treated in an environment unhampered by the excessive security of a prison. Transportation costs would be no more than under the present arrangements where prisoners are transferred from one prison to another, or to outside hospitals. Finally, for reasons given above such a hospital would enable prison medical staff to concentrate on their areas of special expertise, and in a way which is less staff intensive than under the present arrangements.

8. Only two surgical units—those at Liverpool and Parkhurst—are at present operational within the prison system, the former serving the Midland and North Regions and the latter serving, somewhat inadequately due to its smallness and antiquated facilities the South-East and South-West regions.The surgical unit at Grendon, which was by far the

est in the system, was closed in 1982, and that at Wormwood Scrubs has been non-
inctional since December 1981. The policy of providing surgical care within the prison
ervice is based more on security than medical grounds. Yet the only operational unit
apable of taking Category "A" prisoners is Parkhurst where operating facilities and
andards are avowedly inadequate. In practice, the loss of two units has led to no serious
roblems, and much of the surgery that has been, and continues to be, undertaken is of a
osmetic nature only. This being the case, it is debatable whether surgery inside prison is a
ost-effective proposition.

Iospital Accommodation

9. If the older hospitals within the prison system are frequently insufficient for present-
ay needs, it is not always the case that newly designed buildings are ideally suited for the
inctions they are required to serve. One of the reasons for this is a lack of liaison between
ie planners and the people involved in working in the prison. To remedy this it is
ecommended that nursing personnel should in future sit on planning committees.

10. One of the prime requirements for a prison hospital is that it should have a secure
erimeter, in order to provide more freedom of movement. It is far from the case that this
asic requirement is universally met in the prison system, yet it is acknowledged that
xcessive and visible security is detrimental to nursing care.

Iospital Staff

11. Formerly, there was a dearth of properly motivated staff in the prison nursing
ervice. Discipline officers often opted to become hospital officers for the wrong reasons, for
xample, boredom with their present work rather than any vocational feeling for nursing. It
now possible to be more selective, and it is anticipated that most candidates will now join
ie prison service specifically to become hospital officers.

12. It is hoped that eventually all hospital officers will be qualified nurses, and the short-
erm aim is to arrive at a proportion of 30 per cent. We will continue to recruit qualified
urses direct into the service, this being cheaper than training staff internally, though it will
lso be necessary to train staff in post to enrolled nurse level.

13. At present the service is basically divided into male hospital officers and female
ursing staff, each with their own promotion structure. There would seem to be no
dequate justification for this twofold structure, nor any good reason why women should
ot work in male establishments, and vice versa. It is intended, therefore, to have an
ntegrated service.We are committed to start the recruiting and training of female hospital
fficers this financial year. Those nurses who do not wish to be co-opted into the new
ystem will have the choice of remaining in the nursing service, which will eventually
ecome defunct due to staff wastage. A new hybrid term will be required, perhaps the term
nurse officer" which is used in the Scottish system.

14. There is still a shortfall of 130 hospital officers, which, though an improvement on
revious figures, means that many staff are working excessive hours of overtime, to the
ossible detriment of the quality of their work, and with adverse effects on staff morale.
here should be a continued recruitment drive to bring numbers closer to the authorized
affing level and offset staff wastage. An excessive amount of time elapses between the
election process and the taking up of posts. Efforts should be made to shorten this period
o an acceptable level.

15. It would be desirable to have a more extended period of training, both in situ and at
ie regional hospital. There should also be more vocational training for particular roles;
pecially managerial ones. It is important too that staff should have a wide understanding
f prison conditions generally, not merely of the minutiae of prison nursing care, and the
pproach which should be fostered is that of a caring team. To motivate further, it might be
elpful to institute specific vocational examinations for promotions.

16. There is staff dissatisfaction at the lack of parity with nursing outside the prisc system, which the institution of professional qualifications mentioned above will c something to allay. The possibility of secondment to NHS would be desirable able for sta morale, and we would support in general an even greater reciprocity of relations betwe the two services.

17. Where there are mother and baby units in the prison service, it is essential th responsibility for them should be vested in a qualified nurse or person with suitab qualifications. In general, staff with specialist roles, such as dark room assistant compounders, radiographers, should have the required specialist qualifications for the particular work.

18. Medical documentation is a perennial problem, and in the interests of proper nursi care, it is essential that a system is evolved which gives a proper inmate medical recor This, it is felt, has still not been done.

19. Particularly in the busier prisons administrative matters take up a large proportion the staff's time, possibly at the expense of quality of nursing care. Medical officers too a sometimes so occupied with administrative matters, including parliamentary questio petitions, etc, that their time for purely medical duties is unduly restricted. At su establishments, it would be desirable to recruit a medical administrator who could aid t medical officer in non-clinical matters.

Examination of Witnesses

DR JOHN L KILGOUR, Director of Prison Medical Services, and MR PETER BARKER, BEM Head of Prison Nursing Services, called in and examined.

Chairman

1. Dr Kilgour and Mr Barker, can I welcome you to the Committee. We are very glad that you have accepted our invitation to help us. Dr Kilgour, you came into the Prison Medical Services fairly recently in 1983 and you had not, like most of your predecessors worked your way up, as it were, in the Prison Service. There has been a lot of outside interest in the Prison Medical Services, which has been expressed in the specialist medical press and elsewhere and by a large number of organisations that are working with former prisoners. Of course, as we know, there has been a good deal of criticism of some of the aspects of the working of the Prison Medical Services. I wonder if you could start by telling us fairly concisely what your approach to your job is and if you could indicate to us the main areas where you feel changes ought to be made and those areas we would need to concentrate on?

(Dr Kilgour.) Certainly, Madam Chairman. I came back from Geneva where I was a Director of the World Health Organisation. I came back to assist at the request of the then Home Secretary and then Chief Medical Officer to do this particular jo There was felt to be some need for improv ment. Before that I spent 18 or 19 years i the Royal Army Medical Corps, and 1 years in DHSS and it was felt my exper ence would be useful, especially that spe in the UN field. I was involved in draftin the UN code of conduct for prisons an medical services in relation to them. Yo asked me to express concisely what thought then, and still think now, should h changed after two years three months in th job. I had never been inside a British prisc although I had visited some in Switzerlan and the United States. There were sever aspects which struck me as requirin change or improvement. The first thing ver obviously was the question of the numbe of people recruited within the service to d the job which was required. There wer shortfalls. 28 per cent of the full-tim medical posts were vacant, and these we difficult to fill; in number and quality the had been considerable difficulties. The ho pital officer corps was 840 strong within complement of 970, and the nursing cor was short as well by about 20 per cent. TH problem was also the question of morale.

Chairman *Contd.*]

irly consistent barrage of criticisms had rrounded the Service. I do not say that all it was misplaced, but the criticism had in ct got to such a pitch that I thought the orale of the Service was low. In that mosphere the quality of the establishents, the professional environment in hich the staff had been working repreted to me and my very naive and startled es a considerable scope for improvement. surprised me indeed as I went round, and went to 94 out of 116 I think in my parish, d it amazed me really how good the andard was professionally, given the disvantages and obstacles under which the aff were working. There were difficulties. here was the distinct need too, I think, to prove the relationships; not that they ere hostile, but they were not close or derstanding between the Home Office d the DHSS, which was my old Departent before I went to Geneva. There were viously great difficulties, particularly in lation to the transfer of appropriate cases mental disorder, in the speed and effecveness of relationships between individual tablishments and appropriate accommotion in the NHS, usually secure accomodation, because of the nature of the pulation.

2. You mean if the prisoners had to ansfer?

*(*Dr *Kilgour.)* If there were good reasons der the Mental Health Act to transfer, it as difficult to find the accommodation. A cent part of my activities involved visiting e Scottish establishments, where the menlly disordered bed provision was larger. I und in the northern half of Scotland the ngest time it took to transfer a prisoner as three days, whereas over the last 10 ars in England and Wales it could take up six months. Sometimes the transfers were fected within a day, and that is where the lationships are good. That seemed to be area where a considerable amount of ork was needed.

3. Was this refusal because of the doctor charge of the Department in the NHS spital where you wanted to send the isoner was intransigent about accepting isoners? Was that the reason?

*(*Dr *Kilgour.)* When I first came into the b that solution occurred to me as a asonable hypothesis. I do not think I visaged it was anything like as strong as at. I think the basic background was the estion of the availability of accommodaon. There is considerably less available accommodation in England and Wales for this type of prisoner than in Scotland. That is typical I think of the Health Service in Scotland rather than England. The other thing I think is that before the Mental Health Act 1983 came into force, particularly those provisions which came into force in October 1984, the courts did not have the capability of being able to direct the placing of a considerable number of offenders, who in their view should be remanded for reports in a hospital as opposed to a prison. Also in the 1983 Act, those clauses which came into effect in 1984 do provide more muscle for the courts. There are regions where the provision is not as good as elsewhere. The DHSS has a programme for the provision of secure places, and this is advancing at an accelerated pace over that two years ago. So I see already an improvement in the statistics of transfer of cases. If I could give an example of that. In the mid-1970s, it was estimated by prison medical officers that there were something like 700 sentenced and unsentenced inmates they thought should be in hospital rather than prison. Those numbers have now fallen, so at one point last year the sentenced number was down to below 100. Now that number is 124 and the total is 268. I think this is reflecting the larger prison population at the moment. You can never achieve zero, because of the time spent making diagnoses. If the courts send those people to us we have to take them.

4. Do you wish to say anything about the numbers of doctors that are employed in the Prison Medical Services?

*(*Dr *Kilgour.)* Yes, if I may. Madam Chairman, if I say that when I came—forgive the first personal pronoun—I think there were 24 vacant posts out of 98 in the establishment complement, and last week if the four doctors I recruited at the Civil Service Recruiting Board go into the system, we shall be fully recruited, and in the first couple of months we established quite a strong——

Mr Lewis

5. I heard that, but are the medical profession not interested? Is there a reluctance on their part?

*(*Dr *Kilgour.)* There are two reasons if I may say so, I think. The situation was influenced by low morale and low esteem outside and self-esteem within as a result of public attitudes by a fairly hostile Press. One felt if there was an empty page the Prison Medical Services was a safe subject

[Mr Lewis *Contd.*]

to put in and write something fairly pejorative about it. I have tried to overcome this in the last two years, and where something struck me as an opinion unfairly based I have invited the author of it to come and see me and have taken them to the establishment, the idea being that whilst I agree nothing is perfect, I have tried to meet——

Mr Winterton

6. Has it had the desired result?

*(*Dr *Kilgour.)* I do not think I would like to mention names, but there are three who have ceased to write about the Prison Medical Services.

7. You mean in adverse terms?

*(*Dr *Kilgour.)* Actually they have ceased to write about them altogether.

8. They have not sought to redress the balance in any subsequent article?

*(*Dr *Kilgour.)* One did.

Mr Lewis

9. On that point, looking at the country as a whole, where there have been shortages has there been a greater shortage in the northern part of England than the south?

*(*Dr *Kilgour.)* The difference has not been north-south or east-west. It has been more difficult in many cases to put full-timers somewhere remote—often people with wives and family. If you try to find volunteers ready to go to, say, a post in Northumberland or Devon, where they are somewhat removed from social facilities, it is a little more difficult. I cannot offer any inducements above the national rates.

Chairman

10. Would it help if you could do that?

*(*Dr *Kilgour.)* At the moment I have to say I have been successful in recruiting numbers. Could I make the point, and I do not want to make it defensively, I feel myself I am coming in as a therapist in the situation. We have got the numbers up now, not I hope at the cost of any quality. If I may put it this way, which is a crude way of stating it, I have personally recruited them all. Nobody has been taken on without my approval. Of the 31 we have accepted, 14 have held the Membership of the Royal College of Psychiatrists, three have had the first part of it, two of whom are actively pursuing it, four other post-graduates came in and all bar two of the rest have been doctors in general practice.

Mr Galley

11. On the recruitment you have referre to, is it above the numbers you require?

*(*Dr *Kilgour.)* On rough staff numbe each competition attracts about 60. W have then a sift by experience and qualific tions, perhaps there are eight or ten invite to interview of whom three or four a offered appointments.

12. How far is that recruitment proce under your control?

*(*Dr *Kilgour.)* I would say entirely, exce I have to work with the mechanism of th Civil Service Commission. I can say I ha had to take nobody on board I did not wa to take.

13. What is your relationship with th Head of Nursing Services?

*(*Dr *Kilgour.)* Excellent.

14. In a word?

*(*Dr *Kilgour.)* Yes. You asked me to b concise. Perhaps I could make two or thr points quickly. I believe a lot of th criticism or misunderstanding sometimes the Prison Medical Services, which is th medical and nursing and pharmaceutic services, is because there is a feeling that has at least a tendency to burke the fact th it is a secure disciplined service, and I fir this, as you will understand with my bac ground, very considerably analogous wi the Armed Forces Medical Service. I thin if we were able to carry some of th analogies to their logical conclusions, w may get some beneficial results, particu larly, for example, in the non-nurse qual fied officers. But it may also provide son of the answers to the question which raised repeatedly of whether the Priso Medical Service needs to be in the NH Obviously it has high standards—the should be no question of the quality service being less than that—and a conta with the NHS as wide as possible, but does seem to me that there are man analogues to it; in other words, someboc could reasonably say: "Why should not th hospital services in England and Wales, they are in Scotland, have a staff of stat enrolled nurses?" My answer would be, an I have discussed this with my colleagues the Scottish Health Department, and th Prison Board would agree with me on thi the need is for a very high quality and th best professional level of nursing care. B there are also many jobs which require wh I call medical ancillary rather than nursin skills; in other words, the sort of people yo

[r Galley *Contd.*]

ed rather in a doctor's surgery and things e that, and there are those with manage- ent skills as well as medical ancillary lls, and I think in many cases this would l for other skills than those of a qualified rse. He or she would not be necessarily operly trained to do the sort of job we nt, as we see it at the moment and the y it is currently accepted by the Prison ard. I would like to see one in three of the le system hospital officers being nurse alified and the specific provision of men- nurses for appropriate units. I would like see that happen in the next two to three ars. We are at the moment anticipating in out two to three years time there would about 1200 hospital officers in the male stem—at the moment there are about 50 places in the system and I think just out 900 in post. Two and a half years ago, d I am stealing my colleague's thunder, ere were 68 nurses qualified out of 840. at is two and a half years ago, and we are w approaching 130, and we are on course 360 out of 1200, and this is on a specific escale. I do not see why we should not hieve it. One in three will be nurse alified.

Mr Winterton

15. Dr Kilgour, on that same subject, are u saying in, I think, the balanced remarks u make, that many of those who serve thin the prison hospital service can use- ly continue to be drawn from the disci- ne side of the prison service, because of skills they have to develop in that work? (Dr *Kilgour.)* The answer is yes, provided believe they are a suitable person to ke that step. The way I am progressing at moment is that I am at present in touch h the Surgeon General of the Ministry of fence and I am making arrangements to to the RAMC depot at Ash Vale near dershot, and I want to pick up their esent programme of training, with a view looking at—it is for morale as well as iciency—the non-nursing qualification up, which will still be 70 per cent of the spital officers, and I want to see the same temised training schedule that they have.

16. Are you saying you do not think the rrent highly intensive 24 weeks training is equate?

(Dr *Kilgour.)* I think the 24 weeks train- ,which is itself a very considerable im- ovement on what happened up to three rs ago—I take no credit for that as it was eady in being before I was on the ne—has advantages in providing psy- chiatric nurse instruction that I think was missing before. What I would like to see, with Mr Barker, is a progressive systemised system of training.

17. On the visits we have already made we were told time and again after the 24 weeks some of the hospital staff were not terribly keen to go on a course because on a course inevitably they are going to lose income. On the way things are run at the moment a lot of them are in receipt, quite rightly, of overtime, and if they go on a course they do not receive any overtime at all.

*(*Dr *Kilgour.)* No, no. However, can we take the question in two parts, Mr Barker may wish to come in now?

*(*Mr *Barker.)* At that particular stage, the problem with people attending courses is that they are conditioned to a five-day week which, in actual fact, does cut down on the amount of overtime that they can earn when they are in the field. There is an opportunity that when they go back to their establishments at weekends they can work overtime, if they so wish. So there is an opportunity to work the overtime and also to keep up their earning power. However, one has got to realise that there are financial constraints within the Department at the moment, and so this is recognised. Therefore, we might find that there are some establishments which would not want to employ them on an overtime basis. One also has to realise that it might be beneficial to have the potential hospital officer acting as a student at that particular time, with the sort of drawbacks that one might find as a student. Nevertheless, if the salary is such that they have to rely on overtime, then that is something that should be addressed in another Department than ours.

18. Dr Kilgour, before you answer that question, can I put one or two questions to both of you as witnesses today? In the visits that we have made since we have started this inquiry we have been to Parkhurst, Kingston, Winchester and Aylesbury already, and we have got a whole lot more to visit. We have heard about problems being caused particularly by staff shortages. Some also added that there was a lack of resources as well. Perhaps you would comment on both. Could you tell us, therefore, how this is affecting the work of the prison medical services? You have given us already the establishments of both doctors and hospital officers as well, but could you say how you feel the present difficulties can be over-

[Mr Winterton *Contd.*]

come, and how they are actually created by staff shortages?

*(*Dr *Kilgour.)* The answer to the first part is very simple: it is that we have to recruit up to the establishment, because the establishment—or "complement", I should say, using Home Office language—is arrived at by summing together the manpower assessment for each establishment. Therefore, the sum of these, or the total complement, is officially what is regarded as the requirement of staff in order to run the system efficiently.

Chairman

19. Is that satisfactory, bearing in mind that some of the prisons are overcrowded? Does it have a bearing on that?

*(*Dr *Kilgour.)* Yes, overcrowding adds a dimension of its own. There is no doubt at all that this calls for extra work; it is bound to. It is a demand-led system. The prison medical service is essentially demand-led. The effect of that is not only measurable by the numbers of heads within our care, but the sum of the increasing individual demand which is sometimes itself aggravated by the overcrowding. Therefore, with regard to the effect in terms of pharmaceuticals, of time spent with the doctor and things like that, I think that last year we had something like 1.35 million consultations within the system. That sounds good—I mean, it is an impressive figure. It just also happens to be fairly accurate. However, it gives you an idea of how many individual contacts there are between the individuals and the medical staff, the doctors. As I have said, the shortages are not now in the medical staff; the shortages are in the hospital officers and the nurses. That produces its own problems. Mr Barker can comment on that.

Mr Galley

20. How does the work load of doctors within the prison medical service compare (if one can compare it) with the work load of general practitioners and consultants in hospitals?

*(*Dr *Kilgour.)* Forgive me if I say that that is like comparing apples and oranges. I am not trying to be facetious in that reply. This goes to the heart of the question of whether the NHS general practitioner service could take over or provide the whole of the needs of the prison system for medical cover. The work inside the prisons, by the full-time medical officer, includes general practitioner work and includes forensic psychiatric work. About 40 per cent of those wi are now in the system have had specialis psychiatric training. Over 30 per cent ha formal postgraduate qualifications in th speciality, which is a very considerab advance over where it was. Of the last who have been accepted, as I said, 14 them have got formal psychiatric qualific tions. The work that they have to do therefore not only general practitioner wo but environmental health as well, becau they are responsible for the environmen health of the inmates. That means thin like sanitation, things like food, things li the regimes, how long people spend outsi cells, because of the effect of that on ment health, and the kind of surroundings which the facts of custody require them be. On top of all that they have to ma reports to courts, reports for the Paro Board, reports for the local review comm tees, reports by case work which are occ sioned (quite rightly too) by inquiries Members of Parliament and so on. The tot adds up to a fairly staggering amount 20,000 reports per year provided by fu time medical officers. If there are 100 them, you can work it out that it means th are each providing about four of these week. Some of these can be done in couple of hours, some may require four five sessions with an individual and a lot paper to be written as a result.

Mr Winterton

21. Could we ask Mr Barker to deal wi the question I put about staff shortages an the problems that they create? Could I al ask you, Mr Barker—because I think it very much your responsibility, and I Kilgour has just mentioned it—do yo think that in a prison with, shall we say, large number of mentally ill inmates, 30 p cent of trained mental nurses would enough to deal with the problem, or wou this give them in prison equal quality treatment and care with the ordinary la men outside in the National Health Se vice?

*(*Mr *Barker.)* Perhaps I can talk abo recruitment to start with. One would ha expected that by doubling the length of th initial hospital officer's course we wou have a backlog of people who were waitin to train as hospital officers. This has n happened. We can train as many people come forward to be hospital officers. It h been said on many, many occasions—and quote from psychiatrists who have been the prison service—that the standard of ca that is given by hospital officers is ve

[r Winterton *Contd.*]

od, in that they have had the opportunity have nursed mentally sick inmates who e at the lowest level, inmates who could quite aggressive and whom the National ealth Service hospitals would find great fficulty in accepting because of their olent behaviour, their disruptive behav- ur and also the fact that they are likely to have aggressively. So I think that my lleagues—and I call them colleagues have developed an expertise which is ry, very useful in the type of environment which they work. Having said that, there no doubt that within the prison service ere are areas where a mentally qualified rse would be of a distinct advantage. One n talk of places like Grendon, one can k of places like Holloway, where the ecialist type of care that they give could better given by qualified psychiatric rses.

Mr Lewis

22. What percentage of the staff that you in actually leave the service?

(Mr *Barker.)* Very, very few. Of the staff at we train as hospital officers, the percen- ge is very, very small. We find great fficulty in keeping our numbers stable. at is primarily due to the fact that people ire, and so we find great difficulty in eping pace with wastage.

Mr Winterton

23. How could we get more hospital icers, within the prison medical service, alified as mental nurses?

(Mr *Barker.)* One of the ways in which I uld envisage doing it would be to have an iliated type of course, in that part of the ining would be done within the prison vice and the rest of it could be done in e National Health Service. The big prob- n is deciding in which area one would nt to train them; would one want to train em as a general nurse with a general ckground, or as a psychiatric nurse with a ychiatric background? There is no doubt t there is a smattering of both expertises t are required, and so it would be very fficult to come up with a single training odule that would be suitable for a hospital icer. Having said that, perhaps one uld tend to lean more towards the ychiatric side of things. It would be very fficult at this time, with the staff shortages t we have, to second people out to ining.

24. Have you got any proposals to put to this Committee this afternoon, as to how we could solve this problem of staff shortages? I put the same question to Dr Kilgour. I do not think it is entirely money, is it?

(Mr *Barker.)* No. I would think that one of the ways of solving the problem would be by direct recruitment, and that is to recruit suitably qualified nurses as hospital officers into the prison nursing service. That would be one way to do it.

Rev Smyth

25. Are there any objections to that going on, from any source within the prison service?

(Mr *Barker.)* There is a great deal of anxiety from hospital officers within the prison service who see that by recruiting qualified nurses as hospital officers their own position might be jeopardised as regards promotion, in that on promotion boards people who are qualified might have preference over people who are not qualified.

Mr Winterton

26. Is there an excess of nurses within the National Health Service? I believe that there is not, or that if there is it is only regional. Therefore, is it realistic to suggest that direct recruitment would positively assist?

(Mr *Barker.)* Dr Kilgour and I met Mrs Poole, the Chief Nursing Officer, a matter of a few weeks ago, who expressed great anxiety that we might be taking nurses from the pool that is within the National Health Service. That is perfectly true.

Mr Favell

27. In the prison service do people not involved with the medical side prefer to see nursing officers with experience of being prison officers—pure prison officers first?

(Mr *Barker.)* I can speak from my own experience and say that most psychiatrists like to have hospital officers who have been trained within the service, to look after their patients. I am also a qualified nurse but suggest that a discipline training would better equip the hospital officer, whose expertise should be recognised. He does a very valuable job.

28. Were you a pure prison officer first, before you became a nursing officer?

(Mr *Barker.)* No, I was a qualified nurse before I joined the prison service. I fortunately had to go through the course to become a hospital officer. In those days it

[Mr Favell *Contd.*]

was an eight-week course. I did not think it was fair at that particular time, but I thought the experience was valuable. I also trained as a discipline officer, and so my experience is purely within the prison service.

Mr Winterton

29. So you think there is a lot to be learnt, for instance, from the army or the services?

*(*Mr *Barker.)* There is no doubt about it.

30. Because of your own background?

*(*Mr *Barker.)* In actual fact, I was in the RAF!

31. Sorry, the services?

*(*Mr *Barker.)* The services, yes.

Mr Galley

32. Is there a route that would be regarded as a norm, or are the backgrounds of hospital officers so varied that you could not say to us that the normal progression into the service is in a particular direction?

*(*Mr *Barker.)* I would like to think that with the type of advertising that we have at the moment we recruit discipline officers into the nursing service who join with a particular need or a particular wish to become a hospital officer. I think that at this particular time we are recruiting well-motivated people to nurse ill inmates within the prison service.

33. Can we go back to doctors for a moment, please? Would you think, Dr Kilgour, that the prison medical service is a lifetime career for a doctor?

*(*Dr *Kilgour.)* I think that if you had asked that question 20 years ago you might have had a slightly different answer than one could give today. Today the, you might say regrettable, facts of life are that people do not want to step off bandwagons, treadmills, however you look at it. In other words, if you do step off something, you tend to have some kind of social or financial setback; that is the usual thing. So people coming in, I believe, do think that they are going to spend the rest of their career in the prison medical service. However, the qualification that you have to make on that remark is that the sort of people I am recruiting for the most part—not entirely, but for the most part—are people who are mature. I am recruiting people aged 35 to 50 in some cases, the people who know what they are about. They are picking a career, if you like, of second choice, because they interested in it. The general-practition background medical officer tends to somebody who has spent quite a long ti in general practice, has done well, impres one. He has then usually become a pa time doctor in the prison service or l stood in as a locum in a prison establi ment. He gets a taste or a feel for it anc interested in the work, then applies for fu time work. He tends to be 35 to 45. T psychiatrically qualified people tend to those who have achieved psychiatric qua fications and, for one reason or another hope are not failed consultants but finding it probably difficult to find a cons tant post where they want to work. Perha I could say here that while I said that I ha taken on 14 who had the membership have also refused nine who had the me bership, for quite different reasons, in t they did not seem to me to be suitable, fr a motivational point of view, to enter service. So when they come in there i sprinkling of ages—one aged 28, one —whom we are prepared to take on a train within the service. These are the o that we particularly want the facilities further training.

Chairman

34. Can I follow that up? Dr Kilgo medical officers of course are required provide psychiatric reports for the cou Do you think that these should be provid ever, or in certain circumstances, by doct who are not qualified as psychiatrists?

*(*Dr *Kilgour.)* In a perfect world, answer would be that I think they sho only be provided by those who have formal psychiatric qualification. Howeve have to say that there are some ve experienced prison medical officers w unfortunately are probably approachi retirement now, who have really a gr deal of knowledge of this very narr speciality of what it is a court needs to kn in a report. They really have a very shre observational eye and a good touch w language, and they can put an assessment a court very well indeed.

35. So experience can be just as valuab and sometimes more so?

*(*Dr *Kilgour.)* I think it is horses courses, that is right.

Mr Galley

36. Are you saying, Dr Kilgour, t one's possible concern that the prison me

Mr Galley *Contd.*]

al service may be seen as a way of getting ut of the NHS rat-race into a more secure ackwater would be incorrect?

*(*Dr *Kilgour.)* I think that if you were to ay that, you would probably say that of the hole of the medical service, and I would ot like to think that that was a general eeling. I would hope that my selection oard procedures, the questions that I ask nd the conclusions we come to on the oard, would eliminate those people, beause I really am not very keen on people ho are just coming in to do as little as ossible to earn their basic salary.

37. Do prison medical officers feel in any ay isolated from the mainstream of NHS ought, policy and development, do you ink?

*(*Dr *Kilgour.)* I would have to say that ome do and some do not. I believe that f those who do, the remedy has often een in their own hands, which they have ther been unwilling to see or did not see, r whatever reason. I hope that that umber is diminishing. I am quite certain at all my recent recruits do not feel that ay. One of the main lines of my urgings nd pleadings to the service has been to sk the medical service representatives in ach establishment to understand, first of l, that they are very much dependent on e resources of the NHS environment in hich the establishment exists. That must ad straight away to the conclusion that ey should be in the closest possible ntact with the local district community ysician,with the accident and emerency department and the specialist deartments of the local district general spital, with the local psychiatric services nd staff and so on and with those who eed to come in (that is, the dentist, the tician and many others who do someing like 3,000 sessions). I am giving you e figures incorrectly there. I could supy those later, if you want me to do that. here are a very large number of regular ssions which are done by specialists ithin the system. What I am trying to say that it would be rather difficult to sustain e argument that people do feel cut off, ithout saying at the same time that that rticular individual was not doing his job roperly in the establishment. I am not ying they all do their job properly in the tablishments, but I think that more and ore of them are doing that and getting rong encouragement to do so.

38. How far do terms and conditions of employment and pay compare with the NHS grades?

*(*Dr *Kilgour.)* You touch a sore spot! I frankly am surprised—I could use a stronger word—that there is not perhaps more feeling expressed about the relative rates of pay. To give you three quick points—and there are many others—the full-time medical officer who is doing general medical work, shall we say, in Brixton, Parkhurst or Winchester, finds himself working side by side with part-time medical officers whom we have to have as locums when the others are otherwise engaged or are away sick or are on holiday, and they find themselves earning very considerably less in terms of take-home pay. Therefore, that gives them a feeling of unfairness. We have at the moment a case with the Treasury, again on the grounds of fairness. I cannot use the argument of lack of recruitment, because obviously I have been able to recruit the people. Therefore, this case is on the grounds of fairness, to the effect that the medical officer class of the Civil Service is employed and—forgive the jargon—he is employed on a contract, he is conditioned to 41 hours a week in London and 42 hours a week elsewhere. The prison medical officer group are the only group uniquely in the medical officer group of the Civil Service who have on-call duties to perform, and there is no financial recognition of this. That seemed to me, right from the beginning, a point of unfairness, if you like. We made a case on this which has been going for about 18 months between the Home Office and the Treasury. The ball is in the Home Office's court at the moment. I am hopeful—I will not say "confident", but I am hopeful—that we shall have a satisfactory outcome in due course. The third point I would make is that medical officers who know what the terms and conditions of their colleagues are who are working in the special hospitals are aware that they can retire earlier, that the final years of their service, because of stress, count for double the years in terms of pension earning. Of course, none of this applies to, I would maintain, the patently arguable case that the prison medical officers are working under certainly equal stress in most of the establishments—that is, the full-timers. These are things which are potent factors, I think.

Mr Winterton

39. Also there is the matter of contributory and non-contributory, is there not?

*(*Dr *Kilgour.)* Yes. Of course, the prison

[Mr Winterton *Contd.*]

medical officer does not have to contribute, just as the Civil Service as a whole is non-contributory. However, taking all that into account, it still leaves the feeling—and not only a feeling but an actuality—that he is worse off.

Chairman

40. Would you be able to let us have a note about the evidence that you have put in about this?

(Dr *Kilgour.)* Yes, I am sure we can.

41. Perhaps you can let us have the figures on different rates of pay?

(Dr *Kilgour.)* Yes.

Mr Galley

42. We have discussed the training of hospital doctors. What about the training of prison medical officers? What additional training is there when they have finished their basic postgraduate training? What about refresher courses at any stage for any of them, at whatever point in their development?

(Dr *Kilgour.)* I will answer the question first of all on the situation as it is, and then on what I hope it will shortly become. As it is at the moment, they are first of all by selection. We are trying to take people up who have already had experience of prisons either as general practitioners or because their forensic psychiatric background has taken them into prisons as part of their work. This is not systematised, but they arrive at their establishment and, as far as can possibly be arranged—which is in most cases—they will go to an establishment where they are not the only doctor, so that they can receive big-brotherly kind of advice and grounding. In the first two or three months, as it can be fitted in, they are sent on a task duty to other establishments. While we have 116 establishments, each one is different in its own way, even though they look alike, in terms of function, their age, their staffing and their kind of inmate, so we try to spread the amount of experience in that way. We have what we call induction courses which last for a week (there is one going on at the moment, by coincidence), where we try to give, over three days, a fairly intensive course at which we invite people like the Director General of the Prison Service, the Head of the Probation Service, the PMOs, Mr Barker of course, to talk to them, with perhaps a legal representative, perhaps the author of the latest paper on the handling of violence, things like this. AIDS at the moment, as you might under stand, is a considerable preoccupation, an people have to understand what our polic is, what our treatment, accommodation an handling of it is. That is the inductio course. Then we have what we call develop ment courses where we try to bring peopl in, both full-timers and part-timers no (which has been a considerable advance), i twenties roughly, on each course. Agai that is a three-day course where we try t take them all through current problems an foreseeable problems. There it tends to b more in terms of management problem such as relationships with the governor legal problems, court problems and thing like this. You asked about continuing trai ing. We have two doctors at the mome who have got the first part of their Membe ship of the Royal College of Psychiatrist who are on courses attached to London an Manchester where they can continue thei studies to complete their qualification. W have hospitals such as Broadmoor as estab lishments where we are detaching people t spend six months just working there o detachment, in order to improve thei experience and to learn at the same time. would like to increase all this, of course. would like to see more of our doctors goin out and doing sessional work. I am talkin of the full-timers now. I would like to se more of them going out and doing sessiona work with the local NHS establishments This is not a new idea by any means, it ha been tried before in various ways in th past. The problems there have been abou this are that it has not always worked ou very well. I will not say that always th faults have been on one side or the other, o even that they have been on any side. Ofte the fault has been organisational; becaus before somebody can become any use t shall we say, a district general hospita doing any work every week as a consultan or an assistant, they have got to be there at particular time and place, at the same tim and place every week, and sometimes th exigencies of the system are that the cannot always turn up because of othe duties. That makes them not the mos popular, shall we say, of people to fill tha kind of slot. However, I would like t encourage it very much. There are man other ways of doing this, which I would lik to see developed. It varies from area to area If you are in Dartmoor, for instance, it is little more difficult to do that—althoug there is a good hospital at Okehampton an another not too far away at Exeter. If yo are in London, of course, it should b

ery much easier. While we were so short of eople, the thought of doing training would roduce a fairly derisive response of "How n earth can we possibly find the time?". ow we are fully recruited, it is another ducational process for me to put across my own colleagues, that "You know ou're now recruited. That argument oesn't hold any more now. We've got to art taking training much more seriously." hat is the position we are in at the oment.

Chairman

43. If the training leads to higher qualifi-tions—as it does outside in the NHS -doctors normally get the higher rate of ay, do they not?

*(*Dr *Kilgour.)* Yes.

44. Would or should this apply to the ison service?

*(*Dr *Kilgour.)* It does not at the moment. Whether it should apply or not, I am not re. As long as we are in the Civil ervice—I have known these arguments ver different parts of my life before, and I now both sides of them—it is very difficult r the Civil Service to pay other than at a ational rate, unless they are specialised lowances of the kind that I mentioned efore. In other words, the on-call allow-nce I think could reasonably be made as a ecific, unique allowance to the prison rvice. What we would say about the ison medical service is that merit should rewarded by promotion. There is a stem called the personal promotion sys-m which is not much used at the moment, t which perhaps could be used more in e prison system to do this.

Mr Favell

45. The Chairman was speaking earlier out reports to courts. As somebody prac-ing in the courts myself, I realise how portant and influential these reports are. ften a bench or a judge would have little ea what to do with a prisoner, but for a port coming from you or from one of your lleagues. I assume, first of all, that you are nscious of that, and that all your officers e conscious of how important those re-rts are?

*(*Dr *Kilgour.)* Indeed.

46. Do they find them a source of irrita-n in terms of the amount of time involved preparing the reports?

*(*Dr *Kilgour.)* I do not think it is irritation; only that it is a very time-consuming but necessary and unavoidable part of their task.

47. Do you think it ever leads to a conflict between a doctor's responsibility to his patient and his responsibility to the system or to the management that he is involved in?

*(*Dr *Kilgour.)* This is a very important question which I have addressed my own mind to several times. To me, I can understand that people could perceive the possibility of such an interference occurring. I do not believe that it does or could. It has never survived my attention in a particular place with particular people, after we have gone into it together. In my view, it is quite clear that the prison medical officer is concerned with—I am quoting, I am sorry—"the mental and physical health of the inmates in his charge", and that is part one. The previous Home Secretary and the present Home Secretary have both heard me saying—and they both agree—that there is no question of there being any interference of any kind with the professional judgment of the doctor on what is necessary, in his professional view, for the mental and physical well-being of the individual, again within the facts of custody—because obviously that overshadows everything.

Chairman

48. We have not yet got to the stage of allowing conjugal visits in the prison service?

*(*Dr *Kilgour.)* That is right.

49. Although some systems do allow that?

*(*Dr *Kilgour.)* Yes indeed. That may or may not be conducive to the physical and mental well-being of the individual!

50. It might, on the other hand, so they tell us!

*(*Dr *Kilgour.)* Yes indeed. The prison medical officer, of course, is employed by the system, but he is employed to look after the mental and physical well-being of the individual. I think he should take part in the management of the establishment, because it is only by doing that that he can express views on the environmental health, sanitation, warmth, fresh air and nutrition which are for the well-being of the inmates as a group. So, to me, if anybody finds such a dilemma, I invite them to bring their problem to me, and we resolve it together usually.

Mr Favell

51. I am not criticising the quality of reports to courts, but do you actually ever carry out any checks on the quality of reports going to courts?
*(*Dr *Kilgour.)* Yes.

52. Do you ever receive any complaints from courts about the quality of reports?
*(*Dr *Kilgour.)* Yes. It would be invidious for me to go into details, I think. I hope you will forgive me for not doing that, but if I talk more generally on this the answer to both your questions is yes. I have had occasion to advise people fairly strongly to change their style or method of reporting. In one case certainly, which is current, I have been very concerned about the capacity of a particular individual to make reports at all. While I am recruiting I am also viewing the current stock, shall we say.

53. Do prison doctors often recommend a type of punishment for prisoners?
*(*Dr *Kilgour.)* They should *never* do that, in my view. If they are asked a specific question as to whether a type of punishment would be deleterious in any way, or if there is a medical reason for not doing something, if they are answering a question, then I think that is a reasonable response. However, they should not volunteer what is outside their competence, in my view.

54. You have already answered the question that you *do* think it is right that doctors should have some responsibility for environmental health interests?
*(*Dr *Kilgour.)* Yes, I am sure of that, absolutely certain. If you were to divorce that, you would then have to create another group of people who would have to become specialists in environmental health in prisons. I say this with deep feeling, and if you have been to some of these establishments you will have seen that it is so. It really is a different world in many ways. Unless you know that world, your advice is less likely to get back to the problem.

Rev Smyth

55. Yet we have heard doctors who work in the field saying that they are not trained in environmental health. How do you help them along the line? Is there not a place for occasional cross-checks by those who might come from another world?
*(*Dr *Kilgour.)* This is what I am saying. All the time I am encouraging open doors for this, and I myself have an open door for this. This is what I was saying yesterday to the current induction course for medical officers—therefore, you may take it that it is part of policy that is going on. In my view you may take it for granted that each establishment is going to have some problem or other involving environmental health. At the worst, it is the salmonella outbreak which was traced to the kitchens at Leeds local prison. More mildly, it may be something much less; it may be something to do with faulty drains, or poor heating systems or over-effective heating systems and things like that. It is important, in my view, that prison medical officers should understand that they do not have all the competences to deal with these things and that there is around about them a web of environmental health officers and district medical officers who have the ability and the right to perform in this sphere. The fact that they do not have the right of visitation and inspection at a prison leads me to say that my response to this is that the managing medical officers of each establishment should establish contacts even though there is nothing to worry them; that even if there is nothing going wrong inside the establishment, they should contact the environmental health authorities and invite them to come in and see the establishment, so that when and if something were to go wrong they are not coming in too late and they do not know what it is they are going to. So I would like to see an open-door policy by invitation—not by right—because that is outside my competence.

Mr Winterton

56. Where would the report stand in that situation? If the ruling medical officer at the prison had actually asked an environmental health officer with whom he had established an excellent relationship to come in and produce a report on the hygiene in the kitchens, the hygiene perhaps in the cells, the hygiene elsewhere in the prison, and a report was produced, what would be the status of that report?
*(*Dr *Kilgour.)* To make sure that we entirely understand each other on this before I answer definitively, I would hope that the contact would be made, but not for routine purposes which I would require and expect the prison medical officer to do. However, where something was going wrong, or was about to go wrong or had gone wrong, then I would want, at the fastest possible speed, the local environmental health experts to be involved. A report that they made, therefore, for a

Mr Winterton *Contd.*]

articular situation—this is what I am ying to get at, not routine, but a particular tuation—which has gone wrong, based, as say, on the excellent relationships which I ould expect had been built up, would be assed immediately by the medical officer, I ope, with his subscription and perhaps any mments which would lend strength to ny remedial action which would be needed be taken, to the governor,and he would lso send it to me. I would expect, and so ould my regional staff expect, to have a itable response with suitable remedial ction taken.

Mr Winterton: You have clarified the tuation admirably.

Mr Favell

57. I have one further question on re-orts. Are you happy with courts asking our medical officers for their advice on unishments for prisoners? Do you think at that is appropriate?

(Dr *Kilgour.)* I think that "happy" is the ord that I am sticking on. You see, we are ssentially at the service of the courts. If the urts ask us a question which it is within ir competence to answer, then the answer ould be given. It is this competence to nswer——

58. Would you rather they asked you or ther they did not?

(Dr *Kilgour.)* I would rather they did not, ecause I do not think that it *should* be ithin our competence. There are occasions hen a court will say they will be genuinely zzled as to whether this is a case where a rticular line of action would be more propriate. If it has a medical ingredient, en I think it is quite correct for the edical officer to respond in that way. owever, he has to put it through that test st, before he answers. I am very worried out people, not only in medicine, who ke it upon themselves to answer things hich are really beyond their competence. I ink that that is the cause of a lot of our oblems.

Mr Lewis

59. Dr Kilgour, turning to the question GPs and visiting hospital specialists, how e the general practitioners and visiting spital specialists selected and appointed? an you ensure the quality of the service ovided by the GPs on a part-time basis?

(Dr *Kilgour.)* Yes. I should say that of our 6 establishments, 88 receive their medical ver from part-time general practitioners whose principal source of income and occupation is running a National Health Service practice in the area. Each one of these people is selected by a board, following open advertisements. We try to make sure that we find the right people for that. The same is going to apply—it is not yet—whereby we are working steadily through a whole system of changes whereby we employ people to visit prison (specialists under contract) to do sessions. This applies not only to medical consultants but also to opticians and to dentists. It is dentists at the moment that we have started on—the thin end of the wedge. I was surprised to find when I came that there was very little in the way of solid contractual arrangements—in other words, "How long are you appointed for?", "Is there a date for review?" and things like that, the more normal things one would expect to find in a contractual relationship. I am happy to say that we are now moving ahead to try to make the whole system more businesslike, and we shall do that. If I may say, for instance, that it is my view that some of the problems that we have had in the transfer of the mentally disturbed, the mentally ill, the mentally abnormal offender, to outside NHS hospitals, have occurred because in some cases the prison system had been using the consultant services of psychiatric consultants who did not themselves control beds. This seemed to me—naively—from a management point of view, to be rather a drawback, because it means that somebody could come in and say, "This inmate should be transferred out", and then that is it; whereas what I would like to have and would like to ensure is that the psychiatric consultants whom we do employ should themselves be in control of NHS beds, so that if they make a recommendation they can follow it up by actually taking the patient. I think that this has to be a gradual change. As we move gradually on this line, I believe that this will remove one of the main obstacles to the speedy following up of professional recommendations.

60. Can you get rid of a bad GP? If so, how do you do it?

(Dr *Kilgour.)* There are various ways; there are several powers open to the Civil Service which relate to efficiency. It is sometimes a rather longer and more arduous process for somebody like me, as a medical manager, than I would like. If I had to design a system, I believe it would contain probably rather fewer obstacles towards that desirable end.

Mr Winterton

61. The situation outside the prisons is perhaps even worse than that within the prisons, is it not? If a patient does not like his GP and wishes to leave the GP's panel, sometimes it can be exceedingly difficult to get on another one. Is not that correct?

(Dr *Kilgour.)* No doctor is required to take on a patient against his will, except in very certain specialised circumstances where I think about 15 years ago I can remember the regulations being drafted, when I was in the DHSS, which were designed to make sure that with the very difficult patient, the "misery", would be spread; in other words, that one doctor in one area or one practice would take him or her on for a particular period, then the patient would be passed to another doctor, so that people were not left with such patients.

Mr Lewis

62. What is the role of the visiting psychiatrist or psychotherapist? How is their work evaluated?

(Dr *Kilgour.)* It is a difficult question. I do not think there is a system of evaluation in that sense. They are selected, as I say, now, by advertisements and a board. When I say "now", this is what is about to come. I would go very much along the lines of feeling that the individuals rather select themselves—or will do in the future—because they will be the consultants with an interest in forensic psychiatry, in geographically the right place, controlling beds. That usually points almost straight away to one individual or to a small group of individuals any of whom I believe would be acceptable from our point of view. Not everybody, of course, wants to undertake this line of work.

63. Is the reliance on visiting doctors an efficient and economic way of providing care, in your view?

(Dr *Kilgour.)* Yes, provided the contract is clear, and provided the individuals concerned are competent in the specialty in which they are delivering their care. I believe that it is certainly much more economic than having a central core of fully-paid, full-time individuals having then to tour the country, because then they spend so much time travelling. The other thing is that in a way it would also defeat one of my main aims, which is to integrate more and more closely the establishment and its medical staff in its NHS environment. I am sure that that is a healthy aim.

Chairman

64. We have just been talking abou general practitioners doing part-time wor in prisons, and about visiting specialist such as psychiatrists. *They* could be calle on to determine a prisoner's fitness fc certain forms of punishment, I suppos could they not?

(Dr *Kilgour.)* Yes.

65. Do you think it is appropriate for th prison doctors generally to have to do this

(Dr *Kilgour.)* The question worries m and concerns me very much. May I explai that in my view it is a much more simpl question than you may consider in the wa that you phrased it. There is really only on kind of punishment inside the prison, an that is cellular confinement. The days c flogging and of bread and water and all tha are long gone. Some of the rules an regulations which we have——

66. ——are a hangover from those days I suppose?

(Dr *Kilgour.)* Exactly. I gave evidence t the Prior Committee. They were kin enough to think that quite a lot of m evidence was useful, and it appears in th Prior Report. There was one point—and am citing this because I think it is a example—where they recommended change in the certificate which a medica officer is required to produce for an adjudi cation committee, on the day that a individual inmate is being charged an being brought before an adjudication com mittee. Quite rightly, they require it to say "Is he fit enough to appear at all? If h appears, is he mentally balanced enough t understand what is going on?". These ar perfectly reasonable things to ask a medica officer to do. Then at present there is question to the medical officer: "Is he fit fc punishment?". Now "fit for punishment" as I say, means cellular confinement. Tha worries me very much, because that imme diately appears to put the doctor in position of saying: "Fit for punishment". look to anybody from outside and fron inside as if he were recommending punish ment almost. To the inmate population i must make them feel that the doctor, asid from looking after *his* personal mental an physical health, is in fact on the side of th people who are going to punish him. So th Prior Committee changed the certificate bu left in, curiously, the recommendation tha the medical officer should certify "Fit fc cellular punishment", because that was th only punishment. The further point which

anted to be taken aboard, and which I elieve will be taken aboard in any imple- entation of changes which may flow from ne Prior Committee, will be to leave a pace for the medical officer to fill in, which ill just say: "Give any reasons why cellular onfinement is contra-indicated for medical easons". Nine times out of ten that will be ft blank, but on the tenth time it means at the only time the medical officer needs say something positive will be on behalf , protective towards, the inmate, rather an giving a carte blanche for punishment.

Mr Winterton

67. Putting it more bluntly, who else ould possibly answer a question in the way at you have phrased it, or in any other ay? It must surely be the prison doctor, in ny situation?

*(*Dr *Kilgour.)* Yes, it is rather like saying at a glass is half full and a glass is half npty; it is the same glass. However, if you ked the doctor only to say something in is particular context, if there is a reason hy something should not be done which ould be damaging, that seems to me to be right thing for a doctor to say; whereas to y that he is fit for something, whether or ot he is going to be sentenced for it, seems me to be wrong.

Mr Galley

68. What methods do you apply to iden- y mentally disordered inmates? Would it true to say that the numbers of the entally disordered are growing?

*(*Dr *Kilgour.)* Yes, the numbers are cer- nly growing, because, of course, the pulation is growing. Whether the propor- ns are growing is still open to argument. n I answer *that* part of the question first d then come back to the first part of what u were asking? It again surprised me that ere was so little evidence available on the ychiatric profile of the prison population. this moment letters are going out to edical officers, who have already been epared by a previous letter from me, to ke a snapshot of the prison population, th a view to trying to identify, by agnosis and by possible disposal, as to ere they should better be nursed and ated. You might almost say that this is a ychiatric profile of the whole prison oulation. There has been quite a lot of rk done over the last 50 years from time time, which has been made up of small mples here or a larger sample there, but hing really definitive. I am hoping very soon, therefore, that I shall have for the first time something on which I could base management decisions, which will therefore be very helpful, I hope, for the future, in deciding what kind of specialist facilities the prison system ought to be offering for that much larger number. We have talked about those who come within the criteria of the Mental Health Act. There is a much larger number of people within the prison system who exhibit bizarre behaviour, for reasons probably to do with the fact—not entirely, of course, but this is the case for many of them—that they have some mental abnormality. If we could identify much more clearly what the numbers are, we could then start taking decisions about where, how many and what size small special units there should be, which I do not think would involve much in the way of resource consumption but would involve probably special training of staff in handling them.

69. So you may need to evolve new treatment policies—or perhaps for the first time treatment policies—for the whole range of mental disorders?

*(*Dr *Kilgour.)* Yes, I think this opens the door for a completely new approach to the provision of the accommodation, handling and treatment of those who need it. I am thinking particularly of people like the inadequates within the system. We have got a lot of people like that. In the outside context we have got some poor people heavily institutionalised, who drift in and out of the prison system.

Mr Winterton

70. They should not be in the prison system, should they?

*(*Dr *Kilgour.)* That is entirely appropriate.

71. Is not the situation growing worse because of the care in the community programme being carried through without adequate facilities and skilled personnel in the community?

*(*Dr *Kilgour.)* Mr Winterton, those are your words.

72. But do you agree with them?

*(*Dr *Kilgour.)* I think it is beyond my competence to say. All I know is that I have a system which has to provide an appropriate—I hope—respectable, professional service, and which is related to the demands put upon it. What I find at the moment is that I do not believe—for various quite good reasons some of them, that it would

[Mr Winterton *Contd.*]

take me a long time to develop, but I would be happy to develop them—that the prison system felt it was right that it should become a sort of substitute NHS for those who are within the system. Now that we have got the 1983 Act on the Statute Book—and it is beginning all the time to work better, in my view—we have to look at the larger numbers of people who do exhibit bizarre behaviour, for whom we should be making more specialised provision.

73. Bearing in mind your own sensitive position, which I think all Members of the Committee accept, you would not disagree with the views that I have expressed, however?

*(*Dr *Kilgour.)* You are using my own argument! Yes.

Chairman

74. What about mentally disordered women being sent to prison? We have had very bad publicity about Holloway, for example, have we not, which is very disturbing?

*(*Dr *Kilgour.)* Yes indeed. I am profoundly aware of that, and I am deeply disturbed myself by it.

75. I have visited women prisoners in Holloway.

*(*Dr *Kilgour.)* I know your experience, and I am profoundly disturbed by this. Holloway is a particular problem, because among the 11 establishments in England and Wales which cater for female offenders, it holds a very large place. It was the product in the 1960s of the time when people thought two or three things which have not held up against the evidence, one of which was that no women should be in prison, for all kinds of reasons—it was nice of people to think of those reasons, but perhaps not very practical, I think—that crime was a disease, and that psychotherapy was the magic wand that cured that disease. Psychotherapy is enormously important. Psychiatry is enormously important. I must say that, because I am not a psychiatrist and so I may be misinterpreted. I do not feel that at all. The next thing to say is that the women form 3 per cent of the total of the prison population.

76. They are much more law-abiding than the men!

*(*Dr *Kilgour.)* You could say that. There are other possible reasons for that. One of the reactions that people say, of course, is that you have to be very mad or very bad a woman to get into prison at all. Th means that the people we do get in this ver large establishment in Holloway tend to b people who are difficult to handle. So w have a very high concentration of difficu people in Holloway, and it does provide very worrying problem.

Mr Favell

77. Going back to this business about th increasing number of inadequates endi up in the prison system, and the possib relationship with the emphasis on care the community rather than on a close community, I do not want to put words in your mouth, but I am sure you are n suggesting, are you, that people should b kept locked up in case they might commit crime one day?

*(*Dr *Kilgour.)* No, certainly not.

78. This is bound to be a problem whic arises out of care in the community. The is bound to be *some* increase, one wou expect, anywhere, from care in the comm nity. However, would you agree that this a risk that society has to take?

*(*Dr *Kilgour.)* I preface my response aga with the fact that I am Director of th Prison Medical Service, and therefore be this in mind. I have said publicly, at a joi meeting of the DHSS and the Royal Co lege of Psychiatrists, which was held in th Royal College of Physicians about a ye ago, that it was a source of worry to me th there might be—and I am picking my wor carefully—an increasing flow of the instit tionalised, mentally inadequate or mental abnormal, with the final decanting of, sa the last and the most difficult 10 per cent the 70,000 beds which I think are due to closed over the next few years, and befo perhaps in some cases there might sufficient appropriate facilities in the co munity provided for them. This was, as say, a source of worry and concern to m This adds fuel to my desire to make th case—if there *is* a case—for providing mo facilities or more appropriate facilitie within the prison system to deal with the should this fear materialise.

79. How about facilities within the NH to deal with inadequates, rather than with the prison system?

*(*Dr *Kilgour.)* That is my feeling ve much.

80. They do not make the course in th community, do they?

Dr *Kilgour.)* That is right. The trouble is t there are people who are so difficult, o are so socially deviant or aberrant in ir behaviour, but who also are inade- ate, and this is part of the reason for the blem or for the offence, in that magis- es courts do not know what else to do. is is one of the problems.

1. How would you tackle that problem, how would you like to see that problem kled?

Dr *Kilgour.)* I think one has to decide at the size of the problem is going to be, l what are the best kind of facilities to vide for it. That has not yet been too arly decided.

2. And needs to be decided?

Dr *Kilgour.)* I think it does, because it is clear as a bell that these people exist. ey are a problem. They are being ndled in one way at the moment, and one st hope that they do not inappropriately rease the overcrowding problem which sts already in the prison system.

Chairman

3. How much is it a problem to treat y disturbed, mentally disordered patients prison? Patients can still withhold their sent, can they not, in prison, for treat- nt?

Dr *Kilgour.)* Yes, they can. There are aspects to this, one of which you just nted out to me. One I mention in sing, but which is very real, is that one redictable, aggressive, aberrant capable deviant behaviour can create a quite roportionate amount of alarm not only taff but to other inmates. There is really te a large resource consequence to hav- more than a very small number of these ple in the system.

4. In terms of staff, you mean?

Dr *Kilgour.)* In terms of staff, in terms of ommodation. The other side of it, as you tly say, is that we can diagnose an vidual as having a mental disorder, or n a physical disorder, but it is primarily he mental field that we are talking, and know that there they require treatment that if they do not consent to treatment have no power to give treatment without consent of the individual, except in very rly defined circumstances which I am you have heard of or read of before ich are that the individual's own life is sidered to be in danger, somebody else's is considered to be in danger, or that an irretrievable deterioration in condition will occur unless they are treated). However, where there is time, even in those circumstances, my strong advice to prison medical staff is: "Always get a second medical opinion".

85. Would you like to see prison hospitals designated under the terms of the Mental Health Act as hospitals to which mentally disordered people can be committed for treatment?

*(*Dr *Kilgour.)* My answer to that is no, because I do not think that that is what the prison system is for.

86. Would this not make it easier if you have got a very severely disordered patient to deal with?

*(*Dr *Kilgour.)* I think that then we ought to be able to transfer them to the appropriate place for them to receive treatment. If there are time delays in doing that, our effort too should be to obviate those delays. Forgive me being as strongly expressive as that on this subject. It is a perfectly arguable case that the prison system should have its own hospital service, if you like, and a completely separate doubling-up on the NHS system. This would remove all these problems, because we could then recruit the staff, we would have the buildings to do it in, and these problems would not arise, because we could go ahead with the treatment. However, it would be very expensive indeed, and I think there is certainly an equally strong case for saying that people would suspect that it was not as well run as the facilities in the NHS, and that therefore it should not be done.

87. Does not it create problems for the nursing service in the prison?

*(*Dr *Kilgour.)* Yes, I think it would, there is no doubt about that, because one would not want to duplicate the care that could be given outside, and I doubt whether the facilities are suitable within a prison to run a regime which would help the patient, were he a psychiatric patient.

Chairman: I think that possibly we ought to stop here.

Mr Galley: I would like to follow up the point about drug prescribing policies.

Chairman

88. We cannot complete all the questions which we would like to put to you, so we shall have to have another session with you, if that is all right?

[Chairman *Contd.*]

*(*Dr *Kilgour.)* We shall be delighted to have that at any convenient moment.

Mr Galley

89. This is to tie up with the point that came up about five minutes ago, about drug prescribing. Would you confirm, Dr Kilgour, that drugs would not be prescribed without contact with a doctor in the prisons, other than in the circumstances which you outlined, which are the circumstances with which we are very familiar?

*(*Dr *Kilgour.)* Yes, I can say that. I have to say here that I am thinking particularly of drugs which are designed to damp down violent behaviour, because this is the kind of situation which really causes the problems. I would hope that for the normal kind of thing, such as if you had a cold, you would get an aspirin and things like this; that this would be a normal doctor/patient relationship, as you would find in a general practice anyway.

90. Would it be totally unacceptable for a prison officer, without a medical officer being present, to administer a drug to endeavour to control somebody's behaviour?

*(*Dr *Kilgour.)* It is sometimes the practice —in special hospitals, for instance—for a standing instruction to be left, where there is the possibility, shall we say, during the night hours, of an individual who has been known to be violent before, having another such time; a standing prescription, strictly within the limitations of that situation, could be left for a properly qualified person, somebody whom the doctor trusted, to do that (because it is the doctor's responsibility that he can leave such a standing prescription). That must be in writing and under clearly defined circumstances. There has been more than one case recently—not, I think, in the prison system only, but also outside—where observations have been made that a verbal arrangement or an oral instruction is not sufficient. I would support that very much. It should be in writing, in those circumstances.

*(*Mr *Barker.)* Mr Galley did say "a prison officer". I think you actually mean a member of the nursing staff, do you not?

91. No, I do not.

*(*Mr *Barker.)* You do not mean a hospital officer?

92. No, I do not.

*(*Dr *Kilgour.)* I beg your pardon, absolutely not.

93. That could not apply. I am aligni this to a constituency interest at the m ment, but I mean a normal discipline offi actually to administer a drug.

*(*Dr *Kilgour.)* No, absolutely not.

94. Without a doctor or a hospital offi being present?

*(*Dr *Kilgour.)* No. He would not give even if they were present.

*(*Mr *Barker.)* He would not. He wou not have access to it in any case.

*(*Dr *Kilgour.)* There is no question of thi that would be completely out of the qu tion.

Chairman

95. What sorts of things can prison o cers administer?

*(*Mr *Barker.)* An ordinary discipline o cer can administer nothing at all. If I c clarify that, some time ago prison offic during the night, if there was not a hospi officer available, had aspirins which w available in an office, and sometimes pris officers, if a prisoner complained of headache or a cold, would probably adm ister those. Some years ago there was industrial dispute on behalf of the Pris Officers' Association. They forbade th officers to administer these particular fa ily-type medicines. As such, it has ne been rescinded.

96. Why was that? Did they think peo would save up the aspirins and have overdose of aspirins?

*(*Mr *Barker.)* No. I am well aware of t background; it was to do with a hospi officer claiming excessive amounts of ov time for coming in to do things like th and management trying to stop it. As result of this there was an industrial dispu Perhaps I can first explain that, say, in small establishment there might be just o hospital officer on duty. During the nig time, he would be on call; if a prison complained of a headache, he could co in and be paid a minimum of three hou overtime for making that visit. It was fou that at a weekend at this particular esta lishment a hospital officer was coming three times on his off-duty day and gettin minimum of three hours' overtime.

97. But who would have called him in

*(*Mr *Barker.)* The discipline officer. small establishments where there is only skeleton staff—say, there is one hospi officer—one could not expect him to be

airman *Contd.*]

y all the time. This is going back some rs. Things have changed since.

Chairman: I see. I think we ought to clude there. We have still got quite a nber of things that we would like to put to you, so may I ask our staff to get in touch with you and fix another date when we shall pick up from where we have left off. Thank you very much indeed for your help. We are most grateful to you both.

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SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

Wednesday 27 November 1985

British Medical Association

Sir Douglas Black, Dr M Faulk and Dr N Hindson

Prison Medical Association

Dr P A Trafford, Dr B D Cooper and Dr P McErlean

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WEDNESDAY 27 NOVEMBER 1985

Members present:

Sir David Price, in the Chair

Mrs Edwina Currie
Mr Tony Favell
Mr Roy Galley
Mr Ron Lewis
Mr Terry Patchett
Mrs Renée Short

Memorandum submitted by the British Medical Association

1. INTRODUCTION

1.1 The British Medical Association welcomes the opportunity to submit evidence to the Social Services Committee on its inquiry into the Prison Medical Service. A small working party, which included prison medical officers, was set up to prepare the Association's evidence and in line with the scope of the inquiry by the Social Services Committee, the Working Party concentrated upon the PMS in England and Wales and Northern Ireland.

1.2 The main aims of imprisonment are punishment, deterrence and protection of the public. Any secondary aims, such as rehabilitation, are a bonus. Those responsible for the prisons must decide whether most emphasis is placed upon deterrence, upon rehabilitation or upon humane containment. The aims of the Home Office, which controls the English prisons, fluctuate with the political climate of the country as well as being influenced by current penological opinion. It has been accepted by the prison authorities, however, that prisoners are sent to prison *as* punishment not *for* punishment. This principle is endorsed by the BMA Working Party; it is the deprivation of liberty that is the punishment.

1.3 The largest prison system in the United Kingdom is in England and Wales. It is in fact the only system in the western world to have a large, complex, self-contained prison medical service, doctors having been brought in to look after the health of the prisoners within the system. It has been a common mistake of critics of the PMS to hold doctors responsible for the shortcomings of the prison system, and to credit them with greater responsibility and power in influencing what prisons are about than in fact they have. In general, the influence of doctors on penal policy has been limited. A brief history of the development of the PMS in England and Wales is set out in Appendix I to this memorandum.*

I. ENGLAND AND WALES

2. THE ORGANISATION OF THE PRISON MEDICAL SERVICE AND PROPOSALS FOR CHANGE

2.1 The PMS is organised on a regional basis with central, national management from the Medical Directorate at the Home Office. The Medical Director has a seat on the Prisons Board and he is supported at the Home Office by four Regional Principal Medical Officers (RPMOs). These are administrative posts which carry responsibility for the four regions of the service—South East, Midlands, South West and Northern—as well as special responsibility for particular aspects such as mentally abnormal offenders, women prisoners, training. Doctors working in the prisons feel somewhat isolated by the remoteness of their superiors and an experiment is being tried in the Northern Region whereby the RPMO spends three weeks of every month in Manchester and one week in London. All major establishments have a managing full-time prison medical officer of Principal, Senior or Basic grade. A PMO is in charge of medical services at five prisons—Parkhurst, Wormwood Scrubs, Brixton, Wakefield and Liverpool.

* *Not printed*

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2.2 Medical services are provided by about 100 full-time prison medical officers and by ther doctors whose prime contract is with the NHS but who work part-time in the PMS. ogether they deal with a workload which includes the daily sick parade (varying from 12) 40 patients in a prison with 600 inmates), transfers of prisoners to hospital, court work, ıedical emergencies as well as the 480,000 receptions a year. About two-thirds of the linical care of prisoners is undertaken by NHS general practitioners and psychiatrists who re employed on a part-time or sessional basis. Currently, about 117 general practitioners rovide general medical services on a regular basis (72 of whom are paid medical officer-in-harge allowances) and there are more than 100 visiting psychiatrists. There are many other eneral practitioners and psychiatrists who visit on a casual basis. The full-time prison ıedical officers are based mainly in the larger institutions, and particularly in the remand entres. The PMS relies upon the NHS for specialist hospital services. There is, therefore, onsiderable dependence upon the NHS.

2.3 The Gwynn Committee appointed by the Home Secretary to look into the rganisation of the Prison Medical Service reported in 1964. Serious consideration was iven to a suggestion that the service should be fully amalgamated with the National Iealth Service, but the Committee stopped short of that recommendation. Its best-known roposal was the establishment of psychiatric posts held jointly between the PMS and the IHS. In many instances practical experience of these arrangements was not satisfactory.

2.4 The proposal that the PMS should be taken over by the NHS has often been epeated since then. It has been alleged that the PMS identifies with the Home Office and ıat the prison doctor is seen as a civil servant first and as a doctor second. However, a rison doctor must follow the ethical code accepted by the medical profession in this ountry, and although he must recognise the security and disciplinary requirements of the rison, his professional work must not be controlled by political or administrative onsiderations or directions. This applies regardless of what administrative arrangements re made for providing prison medical services.

2.5 The Working Party has examined the various options for managerial responsibility or the PMS. If the NHS in England and Wales were to take over responsibility for the ork of the PMS, then responsibility for the different medical units in the prisons could be ivided between appropriate district health authorities, or a Special Health Authority could dminister the PMS in its totality with the same relationship to the DHSS as existing pecial Health Authorities. However, if the PMS were to become the responsibility of the HSS it would be competing for funds with health authorities responsible for meeting the eeds of the population outside prison; the PMS would be likely to be low on the list of riorities. Moreover, the Working Party believes that the Department responsible for the rison system and all aspects of a prisoner's welfare, namely the Home Office, cannot brogate responsibility for health. Divided responsibilities would call for liaison rrangements which would make for a cumbersome administration and delays, leading to ıe detriment of the service.

2.6 The Working Party believes that responsibility for the PMS should remain with the Iome Office. It recognises that in Scotland and Northern Ireland the prison medical and ıe national health services exist as separate services albeit administered by the same health epartment. It is, however, the relatively small sizes of the services involved in these ountries that make such an arrangement workable. The vastly greater sizes of the services ı England and Wales militate against translation of the arrangement south of the border. laving said that, the Working Party is convinced that stronger ties should be developed etween the PMS and the NHS for mutual benefit. At the present time many NHS doctors ndertake work for the PMS and it would like to see a two-way movement encouraged by ıterchanges between the two services.

The Professional Content of the Work of Prison Doctors and their Training

3.1 The prison system has many very different types of establishments. Furthermore ıere are several possible component parts within the professional content of any one rison doctor's work—general practice, psychiatry, occupational medicine, community edicine and medical administration. Ideally, doctors recruited to the service should be

accredited in one or other of these specialties and should require relatively limited in-service experience in the application of their skills to the prison setting. However, in the interests of the PMS there should be scope for professional training within the Service to develop particular interests, eg a general practitioner might wish to develop an interest in psychiatry or occupational medicine, and/or in those instances where doctors do not have accreditation[1] they should be encouraged to obtain it in the discipline of their choice. The Working Party recommends that the PMS should examine the possibility of providing some trainee posts of this nature which would be approved by the appropriate Joint Higher Training Committee. Staffing establishments should be such as to allow occasional outside secondment during training, and to allow more senior people to attend refresher courses.

3.2 Continuing education is an essential element of medical life. One way of encouraging this among prison medical officers would be to increase the number of in-service clinical meetings and the payment of expenses for attendance. The terms and conditions should be such as to foster in-service education and training.

4. Recruitment of Prison Doctors

4.1 In the past recruitment to the PMS has received less attention than it deserves. Whilst in these days of potential unemployment it seems to have eased somewhat (in August 1985 there were only three vacancies for prison medical officers compared to 27 vacancies two years previously), it remains a constant anxiety for senior prison doctors, both in terms of numbers and in the quality of applicants.

4.2 Prison medicine is rarely a first-choice career. Overall preference is given to the candidates with a generalist background. The minimum age of entry has recently been lowered from 32 to 28 years. Candidates with a higher qualification in psychiatry are placed, if possible, in remand centre posts.

4.3 Prison doctors are paid as medical civil servants, whose pay scales in the medical officer grade are generally lower than those in the NHS. If the standard of the PMS is to be comparable to the NHS then the terms and conditions of service must be broadly comparable. For example, in the PMS there is no access to merit awards and no comparable recognition of the psychiatric and security stress factor as there is in NHS psychiatric practice.

5. The Maintenance of Professional Standards and Research

5.1 The Working Party has already indicated the need for stronger ties between the PMS and NHS by the interchange of full-time doctors in both services (para 2.6). The provision of health care for prisoners and the working environment of the professionals providing health care should be of a comparable standard to those of the community outside, subject only to requirements of security. It would be of considerable support to the health professionals in their attempts to provide proper health care and to develop new ideas if an independent scheme were to be set up similar to the Health Advisory Service.[2] This would allow occasional visits by teams, including outside experts, who would be free to comment on all aspects of the service locally and to report to the Home Secretary, on the understanding that the latter would make such reports public.

5.2 The potential educational and research opportunities offered by the PMS are far

[1] Accreditation is granted by Joint Higher Training Committees to individuals who have fulfilled certain conditions relating to experience and higher qualifications. The conditions vary for the different branches of medicine but, in general, they require four years postgraduate experience in approved post(s) and/or a higher qualification.

[2] The NHS Hospital Advisory Service was set up in 1969 to help to maintain the standards of management and organisation of patient care in individual hospitals and in the hospital service as a whole by constructive criticism and by propagating good practice and new ideas, and also to advise the Secretary of State about conditions in hospitals. The remit of the Service was extended in 1976 to bring in community health services and personal social services and it was retitled the Health Advisory Service. It does not review matters of individual clinical judgment.

rom fully exploited. The development of close working relationships between the PMS nd appropriate university departments would provide prison doctors with membership of n academic department. Moreover, academic doctors would have an opportunity to carry ut research, into medical care in prisons and the effects of prison life on the inmates, articularly on those serving long sentences.

. Medical Problems in Prison

6.1 Many of the problems of prisons flow from the very large prison population. The risis high-watermark of 40,000 set by Mr Roy Jenkins when he was Home Secretary has ong since been passed. The average daily population in June and July 1985 was about 8,000 (of whom about 10,000 were on remand), and this is expected to rise still further.

6.2 This large prison population is caused by a number of factors, ie the length of time pent on remand in custody as opposed to bail, the length of sentence when convicted, and he tendency for prisons to be used as a place of safety, in the absence of suitable ccommodation in the community, for the mentally disturbed and/or socially inadequate, vho commit minor offences. It has been suggested that remands in custody are prolonged y delays in providing medical reports, but there is little evidence to support this as a ignificant factor. The principal causes appear to be pressure on court facilities and the luration of police investigations.

6.3 There is a lack of hard evidence about the incidence of physical illness among risoners compared to that of their peer groups outside. The common ailments appear to be kin problems, sexually transmitted diseases, orthopaedic conditions resulting from earlier njuries, dental problems, and alcohol and other drug problems. In this connection, the Working Party noted the lack of suitable isolation facilities for AIDS in the prisons that it isited.

6.4 It is the mental health of prisoners which probably constitutes the biggest single task verall for the PMS, so prison doctors must be able to recognise and treat the various nental disorders and be aware of the influence of institutions on the health of inmates. They need suitable accommodation and the support of suitably trained staff.

6.5 There will always be a considerable number of borderline mentally abnormal nmates in prison, who will not fall within the Mental Health Act categories which would ead to a hospital transfer. Many of these are chronically neurotic who are frequently ggressive but rarely psychotic. They may constitute between 20% and 30% of the entenced population and they are people who are rejected wherever they present. The rison system frequently has responsibility for them and HM Prison, Grendon was leveloped partly in response to the need to manage such individuals. The Butler Committee in 1975 was in no doubt that there should be special regional secure units for uch individuals, but progress in this direction has been slow.

6.6 It is current policy for the mentally ill to be transferred from prison to psychiatric ospitals. The movement of patients to special hospitals, such as Broadmoor and Rampton, as improved considerably in recent years. It is still too early to assess how well, in national erms, the regional secure unit system (referred to in para 6.51) will work.

6.7 It is the movement of mentally ill patients from prison to conventional psychiatric ospitals which is currently presenting considerable difficulty to the PMS. The present olicy in the NHS is to move the care of the mentally ill and mentally handicapped away rom mental hospitals out to the community. This is a policy to be welcomed if it is ndertaken with proper planning and adequate resources to enable the community to build p services to cope with this increased responsibility. At the present time however—and his was manifest in the Report on Community Care published by the Social Services Committee earlier this year—such planning and resources have not been made availalble efore the shift towards community care began. District general hospitals have had no real pportunity to provide care for the longer-term mentally ill or the behaviour-disordered; hey are therefore unable to fulfil their responsibility for the whole range of psychiatric atients and are not admitting the more difficult individuals. Whilst some of these

individuals will be absorbed by the regional secure units when they are in operation such units will be overwhelmed unless special attention is given to the problem by health and local authorities to enable psychiatric units to admit the mentally ill from prisons.

6.8 The problems of caring for *women prisoners* suffering from mental illness are similar to those of men. There are enormous difficulties in getting mentally ill women placed from remand prisons. Moreover, there is considerable "acting out" amongst unstable women whose psychiatric disturbance is not of a nature which brings them within the Mental Health Act. This "acting out" may be exacerbated by the conditions and form of their imprisonment. Primarily, this is not a medical matter but there will always be prisoners who are so disturbed that medical assistance is required.

6.9 There has been considerable publicity recently of problems in the psychiatric wing at Holloway Women's Prison. The Holloway Project Committee is seeking urgent action to improve fundamental deficiencies such as the wing's deteriorating physical state and an unclear management structure. The Home Secretary has welcomed the Committee's report and supported its analysis of the situation which might only be properly rectified by moving into purpose-built accommodation, manpower appraisal and the monitoring of staff deployment to ensure the most effective use of resources. The Working Party recognises that these deficiencies in the psychiatric wing at Holloway require urgent attention and emphasize the need for adequate psychiatric support in dealing with those mentally disturbed remand prisoners who cannot be cared for in NHS psychiatric hospitals.

6.10 The incidence of *drug abuse* in prisons in England and Wales is unknown, but it is suspected that it is increasing sharply. Doctors become involved in the problem when patients develop mental disorder as a result of the effects of the drugs, usually drug induced psychoses. This is usually treated by the PMS as it normally responds quite quickly to treatment and the prison doctor advises the inmate accordingly. Sadly, however, facilities within the community are not sufficient to maintain withdrawal from the drug habit after release.

6.11 The incidence of suicide in prison is not as high as frequently stated. There are about 20 suicides per annum in a daily prison population which averages 48,000, but this takes no account of the 480,000 receptions into prison per annum. *Suicides* can be divided into the principal categories of (a) threat of suicide as a deliberate political manipulation, eg hunger strikes amongst prisoners convicted of politically motivated crimes, and (b) threatened or attempted suicide as an expression of mental illness or emotional disturbance.

6.12 In the first category doctors have developed a code of practice which has received general acceptance. Essentially, this depends upon recognising that the suicide threat is indeed manipulation, and the right of a prisoner to refuse food and medical treatment provided he is mentally capable of rational decision-making; the prisoner is informed that no medical steps will be taken to interfere with the man's actions as long as he remains compos mentis. A second medical opinion from outside the prison is sought in these cases.

6.13 In the second group, the aim of the PMS should be to provide a service as good as that in civilian life. If staff in the prison (prison officers, governor classes, welfare officers, etc) have the opportunity to bring any prisoner's mental state to the attention of medical staff and if doctors have facilities for investigation, observation and treatment of the inmate it would help to prevent a suicide taking place. Careful monitoring of the figures for suicide and reappraisal of the cases where a suicide has been successful help to incorporate further preventive measures in future policies. Support for the humane treatment of potential suicides has been given by the recent report of the working group set up by the Secretary of State for Scotland to look into suicide precautions at Glenochil Young Offenders Institution. This recommended a system more like that used in psychiatric hospitals that depends on human contact and team work from nurses, psychiatrists and psychologists.

. Nursing Services

7.1 In England and Wales most nursing care for male prisoners is provided by hospital officers; they are discipline officers who have received the basic 26 week training at schools based at Wormwood Scrubs and Liverpool Prisons. In October 1983 there were 847 hospital officers, of whom 68 were nurse qualified (State Enrolled or State Registered). These figures have now risen to about 1,000 hospital officers, of whom 115 are nurse qualified. It is the policy of the Medical Director to recruit next year up to 360 nurse qualified out of a total number of 1,200 hospital officers and a proportion of them will be registered mental nurses. If adequate numbers of such nurse qualified hospital officers were employed it would greatly improve the care of mentally disturbed prisoners.

7.2 In addition to hospital officers there are about 200 qualified nurses who provide professional nursing care for women prisoners and for men in prison hospitals with a surgical unit. On joining the service these nurses do a four week induction course on aspects of prison work. It is essential that these professional staff have sufficient security training, status and authority to fulfil their responsibilities and that the nursing ratio for the psychiatric beds in the prison system should be comparable to that in the NHS. For example, in a regional secure unit overall there are two nurses to every one patient; in a psychiatric unit in a NHS hospital the ratio would be 1 : 1. In the PMS in terms of nurses the ratio is 1 : 2, but a significant proportion of nurse trained hospital officers would improve the position. Moreover, arrangements might be made for some hospital officers to acquire in-service formal nurse qualifications.

3. The Ethics of Doctors in Prisons

8.1 Doctors in the PMS subscribe to the same ethical code as all other doctors. The guidelines are set out in the BMA Handbook of Medical Ethics, which include the Declaration of Tokyo on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment (Appendix II).* The loss of autonomy implicit in imprisonment (ie the restriction by confinement, compliance with an imposed routine, and constraints on an individual's work and leisure activities) should not extend to any part of an individual's medical treatment. For purely practical reasons, a prisoner cannot usually choose his doctor but, apart from this single restriction, a prisoner has a right to the same medical attention as any other member of society. A prison medical officer's responsibility to, and professional relationship with, his patients is thus the same as that of any doctor working outside prison. His first consideration is patient care and this would be more visibly demonstrated if the distinction between the medical and the disciplinary services in prisons were made quite clear. A prison medical officer's role should be advisory to the governing bodies of prisons and this would enable him to be more actively involved in seeking to improve unsatisfactory prison conditions. In this connection the practice of declaring prisoners fit for punishment—a practice which has been abandoned in the Armed Forces—would be more likely to be seen by prisoners as a protective measure.

8.2 In applying these principles to consent to medical treatment by prisoners (which includes the right to revoke consent, eg by non-compliance with a regime of prescribed drugs) prison medical officers have been supported by Lord Elton, then Minister responsible for prisons, who said in 1982: "Doctors working in prisons have no statutory authority to administer treatment against the wishes of their patients. It would thus be defensible to treat a prisoner against his wishes only if otherwise his life would be endangered, serious harm to him or others would be likely or there would be an irreversible deterioration in his condition. Such emergencies are in practice very rare". This is entirely in accord with the advice given in the BMA Handbook of Medical Ethics.

9. Medical Records

9.1 A medical record is built up in prison from the initial examination on the prisoner's reception. This is available to all other prison doctors who come into contact with the prisoner whilst he is in custody. Attempts to build up a previous medical history are often

* Not printed.

frustrated by absence of NHS records or unwillingness on the part of the prisoner to provide accurate information. There appears to be a need to modernise methods of storing medical information about prisoners so that it is easily retrievable, but it is important to ensure that detailed medical records of prisoners are confidential to the medical department.

10. Occupational Medicine in Prisons

10.1 Many prisoners work whilst serving their sentences and their conditions of work should be of central interest to the doctor and nurse. Good working conditions could be provided if the doctor were in a position to advise on environment, control of hazards and on safety.

10.2 First aid training is an important part of the job in industry and prisoners welcome the opportunity of learning first aid. This would provide valuable contact between the medical staff and healthy prisoners, and encourage the development of working relationships. Every opportunity should be taken to provide health education about such subjects as smoking, exercise and diet.

10.3 Prison staff receive their primary medical care from local general practitioners. The role of the prison doctor vis-à-vis staff could be closely aligned to traditional occupational medicine. He might act in a similar way as the occupational physician in the community, providing such services as pre-employment medical examinations, advice on promotion, on retirement on medical grounds and on conditions of work. He is already on occasion consulted about rehabilitation after sickness or injury and could provide the full range of advice usually provided by an occupational health service.

II. NORTHERN IRELAND

11.1 The Northern Ireland Prison Medical Service dates, in its present form, only from the early 1970s. Previously general practitioners provided part-time medical services to the very small prison population, under contract to the Ministry of Home Affairs which then administered the prison system. In the late 1960s and early 1970s civil disturbance and terrorist crime led to an almost five-fold increase in the prison population, the construction of new prisons, and a radical change in the type of prisoner. In 1974 the Department of Health and Social Services, Northern Ireland, took responsibility for providing the PMS as agents of the Northern Ireland Office (which has succeeded the Ministry of Home Affairs as the Department responsible for prisons). Successive directors of the PMS in England gave advice on the structure and staffing of the service.

11.2 The PMS has an authorised full-time complement of seven doctors: three Senior Medical Officers (SMOs) in charge of medical services in the larger establishments, three Medical Officers (MOs), and a Principal Medical Officer (PMO) at Departmental headquarters directing the service. He reports through a Deputy Chief Medical Officer of the DHSS to the Chief Medical Officer who is professional head of the service. Both CMO and DCMO have other functions unconnected with the prisons. Many general practitioners give medical services to the prisons, some by part-time contract, some on a sessional basis, and some providing "on-call" services out of office hours. There is a part-time post for Consultant Adviser in Forensic Psychiatry, to whom is attached a Senior Registrar (this being a rotational appointment for SRs in psychiatry).

11.3 All other medical services, including a considerable psychiatric contribution, are provided by Health Service staff. The PMS in Northern Ireland is very dependent on the Health Service and its medical staff for specialist services and facilities. Co-operation by Health Service doctors has been facilitated by the compactness of the profession in the Province and, it is believed, by the fact that the same Department administers both Health and Personal Social Services and the PMS.

11.4 The present prison population is about 2,200 of whom roughly two-thirds are prisoners who have been charged with terrorist-type crime. They are predominantly male, mostly quite young, often connected with para-military organisations, and with motivation

different from that of the usual criminal. Compared with England, Northern Ireland prisons do not contain large numbers of the psychologically and socially inadequate, drug addicts, petty criminals and recidivists.

11.5 The experience of recent years has included concerted hunger strikes resulting in 10 deaths; the notorious "dirty protest"; assassinations of prison staff; much hostile propaganda directed at all prison services; high public and indeed international interest in events within Northern Ireland prisons; and a number of inspectorial visits including two by the International Committee of the Red Cross.

11.6 Some of the consequences for the PMS of these various factors are:—

(i) a special need for the PMS visibly to operate according to a professional code of ethics and distinct from the disciplinary systems;

(ii) a particular need for general medical services of high quality and with the ability to adapt quickly to meet unusual problems;

(iii) a relatively small requirement for psychiatric assessment and treatment;

(iv) a readiness to subject itself to critical inspection by outside bodies.

12. Summary of Conclusions and Recommendations

12.1 The experience of those providing the Prison Medical Service in Northern Ireland is salutary for those providing the PMS in England and Wales. Civil disturbance and terrorist crime has meant that the PMS must visibly demonstrate that it operates according to a professional code of ethics and distinct from the disciplinary system, must provide medical services of high quality and must subject itself readily to critical inspection by outside bodies. These criteria have equal force for any prison medical service and if applied, as recommended below, to the PMS in England and Wales would go a long way to removing the criticisms currently directed at the Service.

12.2 Having examined the options for managerial responsibility for the Prison Medical Service the Working Party believes that the Home Office should continue to be the responsible Government Department. However, stronger ties should be developed between the PMS and the National Health Service (paras 2.4–2.6).

12.3 There should be scope for offering professional training within the PMS to develop particular interests, eg psychiatry, occupational health, and doctors should be encouraged to obtain accreditation in the discipline of their choice. The terms and conditions of prison medical officers should foster in-service education and training (paras 3.1 and 3.2).

12.4 If the standard of the PMS is to be comparable to the NHS the terms and conditions of service of doctors in the service must be broadly comparable (para 4.3).

12.5 There should be interchanges between full-time prison medical officers and doctors in the NHS, and educational and research opportunities in the PMS should be fully exploited (paras 2.6 and 5.2).

12.6 Considerable support would be given to health professionals in the prison medical service in the provision of proper health care and the development of new ideas if an independent scheme of visiting teams were to be set up similar to the Health Advisory Service in the NHS (para 5.1).

12.7 The transfer of mentally ill prisoners to conventional psychiatric hospitals must be facilitated (paras 6.7 and 6.8).

12.8 It should be the aim of the PMS to provide as good a service as that in civilian life for prisoners who threaten or attempt suicide as an expression of mental illness or emotional disturbance (para 6.13).

12.9 Qualified nursing staff should have sufficient security training, status and authority to fulfil their responsibilities; if adequate numbers of nursing staff as well as nurse qualified

hospital officers were employed it would greatly improve the care of mentally disturbed prisoners (paras 7.1 and 7.2).

12.10 Doctors in the PMS subscribe to the same ethical code as all doctors: patient care is the first consideration. For purely practical reasons, a prisoner cannot usually choose his doctor but, apart from this single restriction, a prisoner has the same right to medical attention as any other member of society (para 8.1).

12.11 The medical records of prisoners should remain confidential to the medical department (para 9.1).

12.12 The prison doctor should be in a position to advise on environment, control of hazards and safety, to participate with prison management in providing good working conditions and should take every opportunity to provide health education (paras 10.1 and 10.2).

Memorandum submitted by the Prison Medical Association

I. INTRODUCTION

I.1 The Prison Medical Association welcomes the occasion of a review of the prison medical service as an opportunity for the creative reframing of a picture which has become distorted and blurred as a result of viewing from narrow perspectives during the last five to 10 years. Reframing may help the medical service but the framework of the whole prison service requires attention too if medical aspirations are to be realised.

I.2 The Prison Medical Service is required to provide "all necessary medical care" for those received into the penal establishments of England and Wales. It is staffed by between 90 and 100 whole-time medical officers, some 120–130 part-time medical officers (mostly NHS General Practitioners) and a number of visiting specialists, mostly NHS Consultant Psychiatrists employed upon a sessional basis. In male establishments the doctors are supported by teams of hospital officers, a few of whom hold registrable nursing qualifications. Nursing Sisters are employed in two large prison hospitals which provide surgical facilities. In female hospitals the staff comprises nursing grades from a Principal Nursing Officer down to Nursing Assistants and in some the security side of the hospital is maintained by female officers of the discipline staff. The Service could not function without the help of its NHS part-timers, nor could it provide an adequate service without the back up of NHS hospitals for the purpose of acute surgical and medical treatment. It is only among mentally disordered inmates that difficulties are experienced in transferring patients requiring hospital care to NHS hospitals.

I.3 The range of medical services required and provided in penal establishments is extremely varied, the local prisons receiving as they do, every inmate committed from local courts, deal with a great variety of physical and mental problems and have the responsibility of sifting and sorting all new receptions and trying to ensure that their medical needs are met. They act in effect as acute psychiatric assessment centres for all those whose behaviour has brought them into conflict with the law and the use of the "remand to hospital" facilities introduced in the 1983 Mental Health Act cannot be widely applied until there has been a period of assessment in conditions which ensure the safety, both of the defendant and of the public.

I.4 Generalisations about prison medical care are largely valueless because of the very wide differences between the various types of establishments in the Service, and the different sections of the total prison population represented in them. The prison doctor is obliged to provide appropriate medical and psychiatric care no matter what offence the prisoner-patient may have been charged with or convicted of, and no matter how difficult the behaviour of the inmate or how abrasive his personality. There is no question of the doctor "opting-out" and declining to treat as his opposite number may do in hospital or general practice in the National Health Service.

. THE MEDICAL OFFICER

II.1 The Prison Medical Officer needs to be a mature and experienced doctor who is ccustomed to accepting responsibility. In the past many whole-time medical officers have ome into the Service as a second career after many years in General Practice, the Armed orces, the Colonial Medical Service and in some instances, the NHS Hospital Service. As exibility in medical careers becomes more restricted there is a tendency for younger ecruitment into the Prison Medical Service. It is considered that the career grade in the rison Medical Service should be Senior Medical Officer and that post graduate training nould be available to all medical officers to assist them in achieving the grade of Senior Medical Officer whether as specialists (eg in psychiatry or in community health or other pecialties) or as "General Managers". Adequate postgraduate training and refresher ourses, together with the need to meet colleagues within the service more frequently than ne present biennial Medical Officers Conference, require an adequate staffing level and erhaps a "floating" pool of medical officers able to undertake locum duties as part of their n-service training.

II.2 Medical Officers working in local (remand) prisons may be called to the courts to ive expert evidence on the mental state of defendants. They require to hold a psychiatric ualification and they need to work in close liaison with Consultant Psychiatrists in the rea. In the past a few Prison Medical Officers in this position have been able to spend one r two sessions per week working outside the prison. This is an ideal to be aimed at and any pportunity to foster the sharing of duties between suitably qualified prison doctors and Consultant Forensic Psychiatrists, whether working in regional secure units or in onventional hospitals is to be encouraged.

II.3 Suggestions have been made that the prison requires only the "General Manager" ype of medical officer and all his expert opinions could be called in from NHS ractitioners in his immediate area. This is not seen as a working possibility and it would emove job satisfaction from the prison doctor.

Medical Officers require the support of their superiors and this is not always seen to be vailable to them at the present time owing to the remoteness of regional Principal Medical Officers. Senior Medical Officers having oversight of groups of smaller establishments are sually too busy in their main prison to find much time for their commitment to the satellite stablishments.

II.4 The pay scale of the medical officer class in prison has traditionally always been linked to Civil Service grades. This is felt to be inappropriate. Uniquely among Civil Service medical officers, prison doctors are delivering primary medical care as well as all their other duties and their pay should be assessed in relation to their clinical experience, training and responsibilities. At the present time it lags behind the pay of General Practitioners. The environment allowance is a very inadequate compensation for the often unattractive conditions of work and the verbal abuse and sometimes threats of, or actual physical violence offered. It is noted that Consultant Psychiatrists in the NHS are able to retire at the age of 55 on account of the stress of their work. If they choose to stay on they are credited for superannuation purposes "on a two years for one" basis after 20 years service as "Mental Health Officer". Such a system should, we feel, be extended to prison medical officers.

III. ORGANISATION OF THE MEDICAL SERVICE

III.1 Medical policy within the prisons is determined by the Medical Directorate which is staffed by the Director of Prison Medical Services and four Regional Principal Medical Officers one of whom acts also as Assistant Director, together with supporting staff. The medical department of larger prisons is led by a Principal Medical Officer or Senior Medical Officer and every such senior doctor is responsible also for a small cluster of satellite establishments in a supervisory and advisory role. Smaller establishments are usually covered by a part-time medical officer who is basically employed as a NHS General Practitioner.

III.2 As a result of the May Report the Regional Principal Medical Officers have unfortunately been removed from the regional offices so that they no longer function solely as medical advisers to Regional Directors. These are administrative posts with no clinical responsibility and their very remoteness means that prison doctors feel themselves isolated and inadequately supported by their superiors. In 1985 in the North Region the RPMO has been dividing his time between London and the Regional Office in an experiment which has been welcomed by doctors in the field.

Adequate secretarial help is not always available for doctors, nor is there a formal office organisation applied to all prison hospitals. Office organisation (and the filing of medical records) has come to be left to local initiative and its quality depends on the supervising hospital officer working in conjunction with the "managing" medical officer. Medical correspondence should *never* pass through a general typing pool, as happens in some establishments.

III.3 The relationship between the medical officer and the Governor in a prison depends very much on the personalities of the persons involved. The doctor is the adviser to the Governor on all matters affecting health and hygiene of inmates and staff within the prison. He is responsible for the implementation of medical policy and for the professional activities of all his hospital staff, but the Governor is in overall charge of the establishment and controls disciplinary matters within the hospital. The medical officer in charge is regarded as a "member of senior management" but his influence over events in most establishments is not great and many people question the direct involvement of doctors in management (see under "Ethics").

III.4 It has frequently been suggested that the medical care of prisoners should be taken entirely out of Home Office hands and placed under a division of the DHSS. This would be one way of removing the Medical Officer from the dual responsibility of caring for his patients and undertaking some general managerial duties. It would not satisfy the Home Office which is understood to want to retain total responsibility for the prisoners in its care; one can foresee that in the competition for funds available from the Department of Health the prisons would be very low in the pecking order. A system comparable to this proposal has been found to work in Northern Ireland but circumstances there are very different with few prisoners and little psychiatric disturbance among them. There must be a medical contribution to prison management—perhaps this could be at Home Office rather than local level so that the doctor on the ground could concentrate more on his patients.

III.5 Could the Special Hospitals Division of the Department of Health undertake responsibility for the prison medical service as well and so foster a productive interchange of personnel and maximise the use of the nurse training facilities of the special hospitals? Or might one envisage an even wider Forensic Medical Service embracing prisons, special hospitals, regional secure units and the police surgeons? Perhaps later that could be extended to include all the Forensic Science Laboratory and Forensic Pathology services.

III.6 In the present financial climate radical changes do not appear to be practical beyond a review of the medical officers managerial duties where they might conflict with his duty to his patients. The prison doctor must concentrate on health care and not on general administration.

IV. PRISON MEDICAL RECORDS

IV.1 Prisoners on their first reception bring no medical records with them. Every case comes in as an "unknown quantity" until seen on his reception examination by a prison medical officer. The record of this initial examination must provide base line data for compiling an accurate medical history and this record must be available to all other prison doctors who come into contact with that individual during his time in custody. Unfortunately, prison reception medical examinations are frequently hurried and often neglected with the result that the medical record on page 2a (Appendix C)* is valueless. A great many prisoners are not registered with General Practitioners outside and have often

* Not printed.

moved from town to town so that hospital records too are scattered. Information may be withheld by the prisoner or deliberately misleading information may be given and a deal of detective work is frequently required in order to verify and confirm the information. This can be very time consuming and the true facts tend to become lost in a mass of paper work concealed in hospital case papers which do not necessarily remain with a man throughout his sentence.

IV.2 Medical records from previous sentences are not always easily retrieved from filing systems and even when reliable information has been obtained this may not be readily available on a subsequent reception into prison and the whole process is repeated. There seems to be a strong case for the introduction of modern methods of storage of information by computer in order that this information can be easily retrieved on any subsequent reception into any prison in the country. Appropriate safeguards of confidentiality for any such computer system would have to be devised. Under the present system confidential medical information recorded on page 2a of the prison record is available to all members of prison staff who have access to the prison records. This is unsatisfactory. The only medical information which should be contained in the 1150 should be the page 2 (Appendix B)* which merely states the medical officer's assessment of the man's suitability for employment and fitness for physical exercise.

Medical staff are not always kept adequately informed when a prisoner is to be transferred (eg for security reasons) to another establishment and as a result treatment regimes may be interrupted. Such disruption is avoidable and all medical documents should accompany transferred inmates under confidential cover from doctor to doctor, in accordance with Standing Orders.

IV.3 Page 2a of the 1150 is old fashioned and outmoded. It could well be replaced with a modern questionnaire and the inclusion of body charts (front and back) for the recording of injuries, scars and tattoos would be most helpful.

V. PRISON HOSPITALS

V.1 Most prison hospitals offer, in the words of a previous DPMS "good home nursing care" but this does not reach the standard expected in a designated hospital. The majority of patients spending any appreciable time in prison hospitals are those with psychiatric problems and our hospital officers in dealing with the severely mentally disturbed have developed and retained skills, which are now dwindling in the conventional psychiatric hospitals. Prison hospitals are not designated as hospitals under the Mental Health Act as places to which the mentally disordered may be committed for treatment, so that treatment can be administered only with the patient's consent. A case can be argued for the centralisation of specialist hospital units in regional prisons serving groups of satellite establishments. Such units would undoubtedly offer better treatment for the inmate and greater job satisfaction for the doctors involved. Unless the transfer of the mentally disordered into NHS hospitals can be improved there is a strong case for the approval of selected and upgraded prison hospitals as hospitals under the Mental Health Act. Local prisons already act as acute psychiatric assessment centres for those patients whose behaviour is too disturbed for their ready acceptance in local psychiatric hospitals. The hospital of the Young Offenders Centre at Glen Parva functions as a Regional Secure Unit, initiating treatment and arranging further psychiatric care on release from custody.

V.2 The role of HM Prison, Grendon, within the prison system is controversial. Grendon was born in 1962 out of an earlier concept of the treatment of criminality on a medical model—a concept which is now outmoded. Over the years Grendon has contributed to the management of difficult personality disordered inmates who were extremely disruptive within the ordinary prison setting, and it has helped long-term prisoners to cope with the stresses arising from the length of their sentences, but it has been extravagant in its use of doctors and hospital officers in relation to the overall prison population. It is understood that the role of Grendon is to be changed but it is important

* Not printed.

that the public and the medical profession should not be misled into believing that Grendon has a new part to play in curing "criminality".

V.3 Any development of prison hospitals (and the maintenance of the present status of them) requires more hospital officers and a higher standard of training for them. Recognition of nursing qualifications by the Home Office and the employment of more trained nurses, male and female is desirable and an interchange of nursing staff with special hospitals and with regional secure units would improve liaison between all these establishments and increase the flexibility of patient management. Many prison hospitals are experiencing curtailment of medical activities at the present time due to problems of staff shortages but trained hospital officers are still being used for duties which could be carried out by less "valuable" personnel eg as "Call Ups" officers for escorting inmates from their cells to medical clinics. It is also anomalous that hospital officers (albeit additionally qualified as compounders) should have to undertake deputising duties for pharmacists when the latter are on leave. This diversification of the duties of hospital officers is commendable and adds interest to the job but can the Service continue to enjoy the luxury of using them as compounders or as dark room technicians when pharmacists and radiographers could be employed thereby releasing hospital officers for their more immediate duties in contact with prisoners? Is there a place for the appointment of civilian hospital managers in order to relieve hospital Chief Officers and Principal Officers so that they can give more time to nursing duties?

V.4 The writer's prison hospital operates on a ratio of one hospital officer to approximately eight patients. The usually accepted ratio in regional secure units for nursing the mentally disturbed is more than two nurses per patient. Clearly, the prison ratio permits little more than custodial duties and does not even constitute "humane containment" for the mentally ill in prison. Many prison hospitals have no occupational therapy for their patients and no programme of rehabilitation. The drift towards apathy and avolition might be checked by the provision of a "hospital wing" to serve as a half-way house between the prison hospital and the prison proper (or the community).

VI. ETHICAL ASPECTS

VI.1 Prison Medical Officers practise under the same ethical code as their NHS colleagues; this accords with the Declaration of Tokyo (on Torture and Other Cruel, Inhuman or Degrading Treatment and with the guidelines laid down in the BMA Handbook of Medical Ethics. The prison medical officer is in clinical charge of his patients. There is no choice of doctor by the patient and no choice of patient by the doctor. The doctor's primary responsibility must be to the patient and it is to the detriment of the doctor/patient relationship that the doctor is also seen to be involved in management. Medical officers should be advisers to the governing bodies at all levels and this would enable them to take a more active role in fighting unsatisfactory prison conditions. The process of declaring inmates fit for punishment would also then be seen more in the nature of protecting the inmate than in selecting scapegoats. Certification "fit for punishment" has now been abandoned in the Armed Forces.

VI.2 As long as prison hospitals are not designated as such by the Mental Health Act they are outside the jurisdiction of the Mental Health Act Commission so that problems arising over consent to treatment cannot be referred to that body.

The management of food refusers is frequently difficult in prison and can pose agonising decisions which have to be taken by the medical officers. An outside (NHS) Consultant opinion is always obtained in these cases. The doctor's position would be easier were he not involved in the managerial team of the prison.

VI.3 Many prisoner patients are extremely difficult to handle and are litigious by nature. Medical officers would welcome the opportunity to be able to answer more openly the frequent criticisms made of them by ill-informed statements in the Press and other media. The limitations currently placed upon doctors in making comments on such matters are quite unnecessarily restrictive; it is noted that governor grades are permitted to make public statements through their Staff Association as are members of the uniformed discipline staff through the Prison Officers Association.

VII. RESEARCH IN PRISONS

VII.1 Despite the long history of the Prison Service there is little reliable information about the inmate population. There is a need for intensive research into the medical and psychiatric needs of all prisoners coming into the penal system and an urgent need for the assessment of the effects of segregation and of institutionalisation amongst long term prisoners. The present shortage of labour in many prisons draws attention to the need for active employment of men deprived of their liberty. Medical audit is unknown in the Prison Medical Service.

VII.2 Prisons are popularly assumed to have a bad record of suicide but this aspect has been greatly exaggerated. The occurrence of some 20 suicides per annum in a prison population with a daily average of say, 47,000, does not mean that the suicide rate is over 40 per 100,000 (the usually quoted civilian figure is seven per 100,000). The inflated prison figure does not take account of the 480,000 receptions into prison per annum, and it is well known that the first few days in custody are when suicide attempts are most likely. Moreover it must be remembered that behaviour disturbances are probably the direct cause of many of these committals to prison.

VII.3 There is widespread drug abuse among prison inmates. The extent of this abuse is difficult to determine and access to drugs is not easily prevented without curtailment of prison visiting and the implementation of extremely rigorous searching procedures. The size of this problem and the part played by drug abuse in the generation of prison indiscipline has not been determined.

There is no foundation for the widely held belief that problems of physical drug dependence among misusers coming into prison are not properly treated by professionally acceptable methods.

VII.4 Scant attention has been paid in the past to the occupational health of prison staff. There is generally believed to be a high sickness rate among prison officers but this is only one aspect of prison life into which investigation might be directed. A pilot study is now being planned in Bristol.

VIII. HYGIENE IN PRISONS

VIII.1 The medical officer, usually without specific training in matters of community health and occupational medicine is the Governor's adviser on all matters of hygiene in the prison; routine and formal hygiene reports are submitted. These are probably so routine that no account is taken of them but prisons do have an overcrowding problem, particularly in remand wings, and the problem of lack of sanitary facilities in the old prisons and in some new ones will not go away unless positive action is taken. The degrading act of "slopping out" is an anachronism in 1985. The difficulty of cleaning older buildings is a constant problem in many cases, as are infestations with cockroaches and pigeons. Clothing exchanges are not always able to keep pace with the turnover of inmates and the inactivity of a great many through shortage of labour means that a large number of our young prisoners are overweight. There should be an opportunity for an extensive health education programme amongst inmates dealing with such items as healthy eating, smoking, drinking, drug abuse, and infectious diseases, especially hepatitis and AIDS. Well trained nursing staff could undertake teaching and discussion on these subjects.

VIII.2 It would be logical for the Home Office either to open its doors to local Health Authority Community Physicians and Environmental Health Inspectors or to appoint such officers of its own to ensure that the hygiene of prison establishments falls into line with other public buildings which are not Crown property.

IX. PSYCHOLOGICAL SERVICES

IX.1 The present tendency is for prison psychologists to be management orientated. There is a need, largely unmet, for clinical psychologists to assist in the assessment of inmates both for the courts and for the Parole Board.

X. WOMEN IN PRISON

X.1 The number of women in prison is small but the work-load entailed in their care is relatively high. Broadly, they include the most disturbed women in the population outside of the Special Hospitals, and many of them are not amenable to psychiatric treatment. Female prisons and remand centres are few so that inmates are seldom confined in prisons in their home areas. It is tragic that the design of the new Holloway Prison is so unsuitable for its present role, and that the management structure places limits on the medical care that can be exercised.

XI. SUMMARY OF CONCLUSIONS

1. Much criticism of the Prison Medical Service is ill-founded and little is constructive.

2. More than 50% of the medical work-load is carried out by NHS practitioners (GP's and Consultants).

3. The prison medical service has to function within the constraints imposed upon it by the general prison system.

4. The prison Medical Officer requires improved career prospects and terms of service, with more visible support from his superiors. The quality of his/her work could be improved by more in-service training, refresher courses and postgraduate training.

5. There is an urgent need for review of the Medical Officer's managerial role in the prison, and of whether or not he/she requires to be directly accountable to the Home Office in clinical matters.

6. Prison hospitals require better office organisation and proper secretarial/typing assistance.

7. Urgent reform of prison medical records is required with the introduction (with suitable safeguards of confidentiality) of modern computer methods.

8. Occupational and diversional therapy must be made available in prison hospitals.

9. Standards of nursing must be raised by better training of all hospital staff and their numbers must be increased to a strength comparable to that found in NHS hospitals.

10. Medical communications between prisons must be on a doctor to doctor basis. No confidential medical documents should be placed in the prison record (1150).

11. Research is needed into the medical and psychiatric problems of prisoners and the ways in which they could be met.

12. There are hygiene problems facing the prisons which must be remedied; these are outside the remit of the prison medical service.

13. A new approach is required to the problems of women in prison.

14. The Prison Medical Association should be permitted to make public statements on conditions affecting the health of prison inmates.

15. Mental Health Services of the NHS are failing to meet the needs of a group of patients who spend much of their lives in prison.

Examination of Witnesses

SIR DOUGLAS BLACK, Chairman, BMA Working Party set up to prepare evidence on the Prison Medical Service; DR M FAULK, Consultant Forensic Psychiatrist, Knowle Hospital, Fareham, Hampshire, and DR N HINDSON, Medical Officer, HM Remand Centre, Risley, Warrington, British Medical Association; DR P A TRAFFORD, Senior Medical Officer, HM Prison Bristol; DR B D COOPER, Principal Medical Officer, HM Prison Parkhurst, and DR P MCERLEAN, Part-time Medical Officer, HM Prison Kingston, Portsmouth, Prison Medical Association, called in and examined.

Sir David Price

98. Good afternoon, gentlemen. Our Chairman is rather detained and will be joining us later, therefore I am taking the Chair for the moment to start the meeting off. I should be very grateful, Sir Douglas, if you would introduce your substantial team of talented experience in front of us.

*(*Sir *Douglas Black.)* I shall be very happy to do so. I should first of all explain that we are two delegations rolled into one. By some curious chance, the BMA delegation is on the right-hand side and the Prison Medical Officer's Association is on the left-hand side. Heading the Prison Medical Association delegation is Dr Peter Trafford, and I shall leave it to him to introduce his two colleagues on that side. If I may introduce my delegation, on my right is Dr Faulk who is basically a psychiatrist and who takes a strong interest in prison work. Beyond him is Dr Hindson who is from Lancashire and is a full-time medical officer with a psychiatric background.

*(*Dr *Trafford.)* Our team comprises on the far left Dr McErlean who is a part-time medical officer at Kingston Prison, Portsmouth; and beside me is Dr Cooper, Principal Medical Officer, HM Parkhurst Prison. I am Senior Medical Officer at Bristol Prison.

99. Thank you very much. We are grateful to both organisations for your papers. Obviously there is a considerable overlap between the two. Therefore, it did seem best, both for your convenience and for ours, that you came together. You are such a formidable team, the six of you, that I hope between you you will not feel inhibited in answering any question, or that alternatively all six of you will not answer every question!

*(*Dr *Trafford.)* We shall try to avoid that!

100. Perhaps you can work out implicit ground rules. I would like to address the first question to the Prison Medical Association and to Dr Trafford. We understand that the Prison Medical Association is a relatively new organisation?

*(*Dr *Trafford.)* Yes.

101. How long has it been in existence? What proportion of the prison medical officers are its members? Do part-time medical officers, visiting specialists, play an active part? I see that one of your number is such a part-timer.

*(*Dr *Trafford.)* We formed our Association in April 1983. Membership is open to full-time medical officers, to part-time medical officers and to those other doctors employed on regular sessional terms within prison establishments. We have a very high percentage membership amongst whole-timers. Our total membership is around 200. The part-timers, the National Health Service GPs who help us, such as Dr McErlean, are well represented as well, and we have a number of consultant psychiatrists and one or two consultants in other specialities. I can think of a physician, a genito-urinary specialist, one or two extra specialists of that sort who have all joined us in this body.

Mr Lewis

102. You have not any members below doctors, have you, such as nurses, in your organisation?

*(*Dr *Trafford.)* No, this is a medical Association entirely; it is open only to doctors.

Sir David Price

103. What would be your relationship with the BMA? You are sitting here together today, and I imagine most of your members *are* members of the BMA?

*(*Dr *Trafford.)* I think one can say that the majority are members of the BMA, but the association really goes no further than that. This is just coincidence. The BMA is not even concerned with the terms of service of whole-time medical officers in the prisons, because we are Civil Service medical officers, and those matters of our terms of

[Sir David Price *Contd.*]

employment are dealt with by the Institution of Professional Civil Servants. The BMA does, of course, represent National Health Service doctors, and in that respect it also represents the part-timers, because they are basically and principally employed in the National Health Service.

Mr Lewis

104. Do you liaise in any way with the BMA on your particular subject?

*(*Dr *Trafford.)* Only in so far as we happen to have the situation that the prison medical officers have a representative on the Civil Service Medical Officers Group. The BMA has groups of professional specialties of this sort, and there is a Civil Service Medical Officers Group in which we have one seat on the committee of that group.

Sir David Price

105. I think that possibly a little later on we shall come on in more detail to some of the conditions of service of prison medical officers. For the time being, I am trying to establish where you fit into the spectrum of representation. In your paper you refer to the limitations placed upon prison doctors in making public comments in response to criticisms by the media. Could you tell us what restraints are there, what are the difficulties you meet, and has the establishment of the Prison Medical Association enabled you to respond collectively to some of these matters, in a way that may have been a little difficult to do individually?

*(*Dr *Trafford.)* That is a very wide question. Broadly speaking, we are bound, of course, by the terms of civil servants who are not allowed to write to the press, so that if critical letters or allegations are published in the press, we would not as individuals be allowed to make representation to try to correct what we see as false statements. Within the first year of the formation of our Association I did in fact write on one occasion to the Times myself, as Chairman of the Committee, about one particular matter. The Home Office took exception to the fact that I had written, pointing out that our Association was not a recognised staff association, this was something which we had formed ourselves, and we had no official status with the Home Office. I had to accept the rebuke that I should watch what I did in the future. It has not entirely prevented our making our feelings felt on one or two occasions. I hope that by our conduct since then we have gained a little more credibility with our lords and masters in the Home Office, as well as with our colleagues in the BMA who see us as concerned professionals who really want to do something worth while and do something that we see as being right.

106. Have you sought official status and been denied it? What is the current position?

*(*Dr *Trafford.)* Official status, I think, is very difficult. We are not in a position to seek status as a negotiating body to discuss terms of service. We have explored this possibility. We have explored that through the BMA as being an experienced professional body, of course. However, there seems no way round the fact that the Civil Service unions have the total monopoly, and it is a closed shop. The Civil Service union in this case—the IPCS—has the negotiating rights, and they are quite unshakeable in their resolve to retain them; they have no wish to see any change on this.

*(*Sir *Douglas Black.)* I wonder, Sir David, if I might clarify a point which you raised? You ask about the relationship between the Prison Medical Association and the BMA, and of course my colleagues have answered that from the point of view of the Prison Medical Association, but I would like to say that the BMA does have a concern for the terms and conditions of service of all doctors, no matter which is the formal negotiating body for them, so that to some extent explains our interest in the matter, and also of course we were called to give evidence, no doubt, in recognition of that. I ought to clarify that point.

Sir David Price: Could we come on to discuss the structure of the Prison Medical Association and the service as a whole?

Mrs Currie

107. Both the papers that you sent made various suggestions and about who ought to be responsible at Government level for the Prison Medical Service. Could I split it up between you? Dealing with the BMA paper first, in paragraph 2.6 you say quite strongly that you believe that the responsibility for the PMS should remains with the Home Office. You go on later in the same paragraph to say that stronger ties should be developed between the PMS and the NHS for mutual benefit. Now, in an earlier paragraph you also mention that prison

[Mrs Currie *Contd.*]

doctors do feel rather isolated. Could you expand on this? Why are you opposed to a transfer of responsibility?

*(*Sir *Douglas Black.)* We in fact believe both of those things. We do not see them as incompatible. The present situation is that the Prison Medical Service is the responsibility of the Home Office and since the Home Office is also responsible for the totality of the prisons, and all their functioning, that seems to be a reasonable link. On the other hand, we do believe very firmly that isolation is a bad thing for any medical service, and therefore positive and strong steps should be taken to foster links. These already exist very importantly through one mechanism that Dr Trafford mentioned which is that the prison service makes use—if I can use a slightly contentious expression—of many specialists of all kinds who are working in the NHS. So at individual level and as between individual doctors there are already many links but we would like to see this developed by such things as a common training programme to some extent.

108. What is actually stopping the development of all this? Why is not the BMA itself actively involved in encouraging this kind of two-way movement of seminars, training, and so on?

*(*Sir *Douglas Black.)* Well, we *are* encouraging it and we have said so in our evidence. I think it would be more a matter at individual level for the health authorities—who are the people directly controlling doctors—to be fostering this and creating greater opportunities. As your Chairman knows, one of the most difficult aspects of medicine is the training programme and career structure and so on. She grappled with this for many a day, so it is not just the easiest of aspects.

Sir David Price

109. Is one of the problems, Sir Douglas, one which we get in many walks of life —that one's staffing levels are never sufficient in reality (whatever they may be in theory) to allow for sufficient time off, because what with leave and sickness and all the rest of it, one is usually pretty near to the bone on staffing, and if you have too many people off in career training and all the rest of it, it gets very difficult and gets given a lower priority than just keeping the job going.

*(*Sir *Douglas Black.)* That is an extremely valid and interesting analysis for the situation in general. I think for the particular situation in the Prison Medical Service, I would obviously want to draw on the experience of my colleagues if I may.

*(*Dr *Trafford.)* I think there, Chairman, you have hit it right on the head. This I think is very true. It is one of our difficulties—that we have not the time to take a regular afternoon, perhaps, to go and attend a local hospital or to play an active part in the work of a local hospital. We do have some interchange of training programmes. The forensic psychiatry senior registrars often come into our prisons for experience of forensic work, practice at writing reports for courts and this sort of thing, and we are very pleased to see them, but it is difficult even to find time sometimes to supervise and guide and direct them, much as we would like to do so.

Mrs Currie

110. Forgive a slightly simple comment, but I have yet to hear any doctor anywhere in any of the services in this country say "My budget is big enough and I have time to spare"! Could I ask you whether you would agree with the comment that is in the PMA paper in which they say that one of the reasons for not going to the NHS is that in the competition for funds available from the Department of Health, the prisons would be very low in the pecking order. Does that sound about right to you?

*(*Dr *Cooper.)* I think one must be guided by what has actually happened in the past, and the experience of the regional secure units does not fill us with any enthusiasm for the NHS. It might be better for the doctors. I think our status might be improved but I doubt very much whether the end product, the quality and quantity of the service that we give to our patients, would be improved.

111. In paragraph III.5 of your paper you pose a number of questions, and you say "Could the Special Hospitals Division of the Department of Health undertake responsibility" and then you go on to say "Or might one envisage an even wider Forensic Medical Service . . . "—and you do not actually answer your own questions. Could I ask you to do so?

*(*Dr *Trafford.)* Yes, these ideas are not new. They have been floated for ten years

[Mrs Currie *Contd.*]

back to the time of the late Dr Peter Scott, I think. They are left as questions because there has never been any indication whatsoever from the DHSS that they would wish to undertake any responsibility of this sort. There has never been any enthusiasm whatsoever—I think I can say that—from their senior doctors, and I do not think it has been explored any further than that. I think this is really one of these nice ideas. It is like the simple statement "Could the NHS not take over the care of the prisons?", which sounds simple, but the practicalities of it would be simply enormous, and it would be extremely difficult.

Sir David Price

112. Has any study been made to suggest the matter that immediately occurs to me: would they be slotted in at district level, regional level or family practitioner level, because you are doing both, are you not? You are doing the family practitioner work and you are doing quite a lot of the district work?

*(*Dr *Cooper.)* I think what we had in mind was having a national service, a national forensic service, in which perhaps all the medical matters connected with the courts and legal matters should be in one centrally funded division, and we would emphasise "centrally funded", because otherwise I think we would be the Cinderella of the service. It makes sense in some aspects for the special hospitals, perhaps other aspects of forensic medicine, and the prison service, to be in one independent service centrally funded. After all, we are a national service. We do extend all over the country and we do not correspond necessarily to the NHS areas or regions.

Mrs Currie

113. And the patients you are treating may well have medical services at home, or some other part of the country as well?

*(*Dr *Cooper.)* Indeed.

114. Could I ask you about maintaining standards? You have both indicated you would like to see the introduction of an independent inspectorate of some kind—perhaps similar to the Health Advisory Service. Could you give us a little more idea of what it would be, and who you would expect to be inspecting? Would it be doctors, or other health service professionals, or civil servants, or who?

*(*Sir *Douglas Black.)* If I could start, because I am sure Dr Trafford will want to add points, because he knows the detail of it much better than I possibly could, but we were looking at HAS, not as a model but as an analogy, because clearly the difference between the general hospital and medical services provided in prisons is fairly considerable. What we would like would be a two-way thing—a sort of window being opened into the prison service for independent people coming in from outside—not perhaps strictly as an inspectorate, but as colleagues who would make suggestions for improvement, and perhaps add a little bit of steam to see that suggestions were actually implemented, as sometimes needs doing. On the other hand, it would be an opportunity for people working in the prison medical service, both whole time and part time, to draw to the attention of colleagues from outside things that they saw as deficiencies. One would see this as very largely a discussion, and only at the end of the road an actual inspection with really sharp teeth. Sorry if that is lily-livered but that is how we would see it.

115. What sort of teeth would you want it to have?

*(*Sir *Douglas Black.)* At the end of the road, influence with Government departments, possibly with legislators, because there are some slight differences between the legislators and the executive departments of Government which sometimes become apparent.

Sir David Price

116. I think we would be interested if you have, on reflection, any specific points that you would like us to have. You have given us a lead there, Sir Douglas, when you talk of the difference between the legislature and the executive. We are potentially the legislators here, therefore weaknesses that you see there would be very useful to us. Of course, as you know, so often the weaknesses that get picked up are ones of drafting and the courts' interpretation of the intention of Parliament and the language of Parliament. Sometimes, I can assure you, *we* find the language of some of the Bills in front of us obscure. Dr Trafford, would you give us your thoughts?

*(*Dr *Trafford.)* Yes. I think this is a very difficult one, because one sees this more as an advisory service, I think, than a strictly

[Sir David Price *Contd.*]

critically inspectorial system. Basically, many prisoners receive the necessary treatment on a number of items very much more quickly than the people outside who are depending on hospital outpatients to be seen; than long waiting lists for treatment. This is on the plus side. On the negative side, one must admit that there are occasions when medical services are provided under conditions which are far from ideal. This does not necessarily negate the quality of the service, but it reduces the general impression. I think that there is a lot to be said here for opening the doors, letting our colleagues outside—and perhaps not only colleagues but some lay people as well—see the problems of the conditions under which we do work and under which we try to provide a satisfactory service, discussing with them ways in which this could be improved. I do not think it is so much a strictly inspectorial role. I would see it more as opening the doors and letting people know more about what goes on in the prisons.

*(*Sir *Douglas Black.)* I wonder if I could come back here? I only partially answered Mrs Currie's question. There is an important point that I would like to raise, which is that we would certainly see it as involving not only an interchange between doctors, but also an interchange between nurses outside the service and nurses within it. We would see this as an all-level thing, including the physical facilities as well as the personnel.

Mrs Currie

117. The reason that I put that to you is, of course, that HAS, like the NDT and other organisations, I know have now been rolled into one inspectorate and are multidisciplinary, are they not?

*(*Sir *Douglas Black.)* That is how I would see it. I have not discussed this with my colleagues. Certainly some of the prison medical services I would certainly see in the way that you do.

Mr Lewis

118. Perhaps I can go back to what you said a moment ago about opening the prison doors. How would you let people outside see what is going on? Tell us a little more about how you would see this in action?

*(*Dr *Trafford.)* That is extremely awkward, is it not?

119. I am following up the statement you made!

*(*Dr *Trafford.)* I think this really stems from the feeling that we all have that we do not have as much contact with colleagues outside as we should have, for various reasons, most of which are concerned with the number of gates, doors and walls around us which can provide a barrier, and the public does not know what is happening; it is always wondering what is happening.

*(*Dr *McErlean.)* I think it was very helpful, and I enjoyed the visit of your Committee when they came down to HM Prison Kingston, Portsmouth, for laymen to see what prisons are like and what the services are like, because one has no idea what it is like. When I started in the prison service I had various ideas as to what it was going to be like, and it was nothing like that. I think that at local level it is very important for local people to come into the prison. I am very happy in our town to bring in people. Trainee GPs come in when they are in their trainee year. Visiting specialists bring in their various junior staff. I think this is very helpful in the opening up of the rather mysterious, or apparently mysterious, prison medical service which, in my experience, has not been that mysterious or strange.

120. Sir Douglas, would the BMA go along with that?

*(*Sir *Douglas Black.)* Yes.

*(*Dr *Cooper.)* If we practise medicine behind high walls, as such there is always going to be a mystique about it. I for one do not think this business of opening doors and windows is entirely the answer, because we have a duty to protect our patients. They are not goldfish in a bowl, to be viewed at regular intervals. What we *are* interested in is the professional people coming in, evaluating and suggesting the work that we do and how it can be improved. I think it is fair to say that the Prison Medical Inspectorate really has not had the facilities or the capabilities of doing that. There is only one man, and he is overstrained. What we are suggesting is that we use local resources and local specialist resources which *are* available in every area of the country.

Sir David Price

121. There is another aspect which now you have mentioned, and that is the con-

[Sir David Price *Contd.*]

sumer. In the NHS we have the Community Health Councils, and you know they were reviewed fairly recently and came out of the review saying they were important and useful. I wondered whether, in your thinking on this, there is not somehow an element *there* that you ought to consider? Obviously one cannot draw a complete parallel, but when you talk about opening doors and so forth, it is not an unfair point to put to you. How do you get the consumers' view in?

*(*Dr *Trafford.)* The consumers, of course, view their position with very mixed feelings. Some of them, as Dr Cooper said, very much resent a lot of visitors coming round the prison hospital and looking at them —and rightly so, I think. They have their means of talking to outside people and making suggestions, making requests, through the Board of Visitors and so on in the prison. On the whole, I think this system could be applied, but it has a very limited purpose, because our service does not integrate, there is often no outside connection. Our medical attention is provided for a person who perhaps is very often not registered outside with a doctor; their standards of what they like, what they think they should expect to receive by way of medical treatment, are rather unknown. When we undertake treatment, and perhaps want to arrange follow-up, we are still left in mid air, and it is very difficult to arrange any ongoing treatment when that man is going to leave us. So that however much we want to help the patient, we do have difficulties sometimes.

Mr Galley

122. Dr Cooper mentioned, I think, the Prison Medical Inspectorate which would appear to be one man at present. Could you elaborate on his functions at the present time, and how effective that inspection can be? How would you see that present arrangement fitting into an advisory service?

*(*Dr *Cooper.)* As I understand it, and from my knowledge, the Medical Inspectorate is part of the General Inspector's team, so that he is part of the general inspection of a prison. The frequency of that is that Parkhurst, for instance, would be visited once every five years, so it is the frequency of visits that I would criticise to start with. Then the medical representative, who is independent, in many instances has not the time or perhaps the detailed knowledge of what is going on in a particular prison to evaluate the standards of medical care, the quality of medical care, and I think he has an impossible task. If we are going to make that worthwhile, we have got to improve the frequency of visits, we have got to improve the standard of facilities available to the medical inspectorate and it has got to have some sort of bite. In many instances the actual reports that are written concerning the particular prison are not available perhaps for a year or 18 months afterwards.

123. Dr Trafford suggested he was not very happy with the idea of an inspectorial role for the advisory service that we are talking about. Would there not however be some sense in combining the advisory and inspectorial role in one organisation which was particularly looking at the medical services in prisons, rather than looking across the board and would that not help the service in many respects in dispersing any element of suspicion there might be about what is going on?

*(*Dr *Trafford.)* The basic rules of medical practice in the prisons, of course, are laid down in standing orders and so on. There are procedures laid down for doing this, that and the other.

124. But it would be the objective of an advisory service to check whether or not those rules were in accordance with current practice outside the prisons, and secondly whether they were being implemented, and would not that serve a useful function which would be in part inspectorial?

*(*Dr *Trafford.)* I think it could, yes. When you say "inspectorial", one just does not know quite who this report goes to. In what way is it to be used? I do not mind and I think this would help, yes.

125. If we have schools inspectors and their reports are published why should we not have prisons inspected with reports published?

*(*Dr *Cooper.)* The reports *are* published. They are laid before Parliament.

126. All I am suggesting really is an extension of what is going on now.

*(*Dr *Cooper.)* Yes.

Sir David Price

127. It seems to me we have got two ideas running here: one is improvement of the inspectorate system, and the general prison

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inspectorate system with more emphasis on prison inspection and more constructive and more frequent inspections, and the other is what we were talking about a little earlier which is really the idea of friends of the doctors in particular prisons, and you were rather hinting that this would be probably more conveniently done through the local NHS services, and no doubt through chairmen of health authorities and so on. Possibly these things could be arranged through the BMA branches. Is this the sort of idea one might have?

*(*Sir *Douglas Black.)* These are all possibilities, and I think ideally they should perhaps be explored in different areas and different ways. I totally accept your dichotomy between an advisory service which is designed informally to improve conditions of work inside prisons, and the fall back position of an inspectorate which is a general one and not specifically a medical one, and that has the ultimate duty to bring immediate defects to attention.

128. Is there a danger in some prisons of the prison medical staff being very isolated from the general stream of the practice of medicine? I imagine in the larger communities there is far less danger of that, because you have got BMA branches, and all those medical societies and people no doubt according to their choice can belong to them. In Dartmoor, and the Isle of Wight, do the medical staff feel isolated from their brothers and sisters in medicine?

*(*Sir *Douglas Black.)* It is perhaps easier for me to answer that than for someone actually working in the prison medical service, but I would draw attention to the substantial number of people working part time both in community work and in prisons. That is one safeguard against isolation, and the other one is visits on a very regular basis by specialists, and also by family doctors—people like Dr Faulk, who come in from the community and maintain these regular contacts.

*(*Dr *Faulk.)* I think even with regular contacts in which you share the study of the patient, that is not sufficient, I would have thought, from what some doctors in prison have told me. They would prefer the added opportunity of coming out and observing and identifying with the practice of the main stream of medicine. I think you need both things—I think simply outsiders coming in would be insufficient.

Sir David Price: I think that reply takes us on very properly to the next question, which is about training and recruitment.

Mr Galley

129. Both the BMA and the PMA set out some ideas about initial training, and in-service training, in their papers. Could you elaborate on your suggestions?

*(*Sir *Douglas Black.)* Yes. If I could start on this one, because I have had some experience of training programmes in other contexts and of training physicians, I think the aim should always be to have a very flexible training programme so people could move freely from one type of post to another, and in that way gain varied experience. This becomes more difficult for two reasons. You may have career structure problems on which I have already touched, but in addition to that, if you have particular restraints on movement between different types of post, that again is a difficulty, and there has been a tendency for totally inadvertent rigidity to creep in to this whole thing, because with statutory training now for family doctors, a number of posts within hospitals have, as it were, become mortgaged for that purpose. Many things that are on the face of it very desirable, such as, say, the future consultants should have some experience of general practice, have become most difficult to implement, because the posts that would be needed to implement them are mortgaged for other purposes, and people being, on the whole selfish, from time to time give first attention to training within their own specialty branch of medicine, with the very desirable incursion of people from other training programmes, while theoretically very desirable, sometimes being practically difficult to implement. I have obviously no particular experience of training in the prison medical service, but if I were able to give advice, it would be to make the training programmes as flexible as possible so you have as few barriers to recruitment into what perhaps would not be anyone's first choice as a career in medicine, that is a very wide generalisation.

130. You do, Sir Douglas, make this point about accreditation. I am not sure I fully understand the system that exists at present, but that seems to suggest that people should have the opportunity to go into a variety of specialisms and be

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accredited whilst in service, so they have got a very broad base for their training.

*(*Sir *Douglas Black.)* People can usually be accredited in one, two or three at most specialties, or also of course they can be accredited in general practice with perhaps a special interest. What happens is that when they have decided on a particular branch of the profession, they are enrolled as trainees for that branch, advanced trainees, and when they have gone through the requisite number of categories of experience, they then are accredited in that specialty. This has relevance for various contexts, including Europe and if they were ever to be a specialist, it would obviously be relevant to that. Myself—and I do not think this would necessarily be agreed by my colleagues in the prison medical service—I see a fairly close relationship between the prison medical service and other types of occupational medical services. They are rather like prison medical services in not being part of the NHS, but being in that particular case under the Health and Safety Executive, so there is a very loose analogy there, but analogies are sometimes dangerous, and it is not a point I would press because I have not myself the experience of what the prison medical service is.

Sir David Price

131. If we are looking for analogies, is there one with the medical service in the armed forces, or is it completely different?

*(*Sir *Douglas Black.)* I think there *is* a useful analogy here, but again it would be for my colleagues in the prison medical service to develop this in any way.

*(*Dr *Trafford.)* I think that basically the prison medical officer, whatever his specialist interest, has also to be a generalist. I think this is essential. He cannot say, "I'm a psychiatrist" or "I do nothing but psychiatry". He has got to be a general doctor as well. That is why we have in the past tended very much to attract people making the prison medical service a second career, after specialist training perhaps in the Services or in the hospital service sometimes or in general practice, and then they come into the prison service. A doctor, however well qualified when he comes in to work in the special atmosphere of the prison, needs training in the ways of the prison, obviously; he needs experience of prison conditions. I think we are all still learning, there is no question about that. An endeavour is made to meet this by providing new entrants with a basic training course which covers just some aspects of prison life such as security, things which the ordinary doctor has not had to give very much thought to previously perhaps. Then subsequently in his career in the prison service he needs further training if he is to take on a managerial role in the prison medical service. An endeavour has been made to meet this need, by providing a development course after four or five years, something of that sort. This is by no means available to everybody. *I* never went on one, and I do not know whether Dr Cooper did. Certainly a lot of people have slipped round this one, but ideally this should be so. Then in addition to all that, there should be opportunities, in our opinion, for doctors to take a particular interest in, say, psychiatry or whatever, to take special training in their own subject as well. This used to be catered for, in that 15 years ago quite a number of us were able to go on courses and were seconded to the special hospitals and gained experience in this way. More recently, however, we all seem to be kept on the job, and there just have not been the replacements to do the day-to-day work, so that the opportunities for special training in this way are very much less than they were, but I think this is a backward step.

132. This is where I repeat the question I put when we started. Is this due to there being under-provision in the staffing ratios, in other words, there is insufficient provision to allow doctors in the service to take advantage of opportunities which *may* be there, because somebody has just got to go on doing the job at the moment?

*(*Dr *Trafford.)* No. I think that very much bigger demands are being made upon us. We had approximately 100 doctors 15 years ago, I suspect, when the prison population was 30,000 perhaps, and it is now at least half as many again. That is probably a main factor there. Of course, there are financial restraints at the moment on staffing levels in the hospitals, which are causing inefficient working by doctors, because we have not got the staff to service the doctors to do the job they are supposed to be there for. This is causing some restriction of our medical activities.

133. Is this nurses in particular?

*(*Dr *Trafford.)* Hospital officers, yes. We cannot sometimes get the people we want to

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see brought to us to be examined. We are just told, "Sorry, no staff, sir. Try again tomorrow." It is a funny way of delivering medical care.

Mr Galley

134. Dr Trafford, you do say, in your summary of conclusions, that "Standards of nursing must be raised by better training of all hospital staff and their numbers must be increased to a strength comparable to that found in NHS hospitals." How great is the disparity at present, and how far can you make a direct comparison between the prison medical service and the NHS?

*(*Dr *Trafford.)* One cannot generalise on this. Every prison has its own character in this respect. I happen to work in a local prison. The local prison is the acute psychiatric assessment centre for the district. The people who are too disturbed to be in hospital tend to finish up in prison instead. So that of 25 patients at any one time, we have probably got 20 who are mental observation cases; they are of the nature who would be on an acute admission ward in, if I dare use the term, an old-fashioned psychiatric hospital, where they would be nursed with a high staff-to-patient ratio which would probably be—Dr Faulk would probably correct me on this—one to one, something like that.

*(*Dr *Faulk.)* I am not quite sure what you mean by "one to one".

*(*Dr *Trafford.)* Or perhaps we should compare it with the modern staffing levels of a regional secure unit, which Dr Faulk I am sure *can* tell us. In my case, if we have 25 patients in the hospital, we usually have three hospital officers looking after them during the daytime and one at night. These include a number of acutely disturbed patients. Their role is purely custodial. I do not see this as anything more. They cannot devote the time to individual patients.

Sir David Price

135. Does that mean in practice, if they *are* very disturbed, that you may find yourself having to sedate more? We have come across this in one or two NHS hospitals where the manning levels are low.

*(*Dr *Trafford.)* Not necessarily, but I suppose it must be a factor. Yes, I think it must be a factor, but it is not necessarily so.

136. Dr Faulk, I think you wanted to come in here, did you not?

*(*Dr *Faulk.)* Yes, as to the staffing levels. In the NHS, in, say, 25 beds, one would expect on a shift not three staff but six or seven, that sort of number. That would be well staffed. If the patients are more disturbed and you are short of staff, in the prison setting you may not be *able* to sedate them unless the patient is willing, because you cannot do that unless it is a serious life-threatening situation almost. What you would have to do is seclude. I think that the big difference you would find between a prison acute admission ward, as Dr Trafford says it, and a hospital one is the extent of seclusion, which would be much greater in the prison one.

*(*Dr *Hindson.)* I think that that is a very important point that Dr Faulk has just raised, as to what happens, particularly with the question of the nurse-to-patient ratio. In our female hospital we have all qualified female nursing staff. For 34 beds, which we have in our female hospital wing, there are 17 qualified nurses as the staffing ratio. That is a quarter of the number of nurses that our colleagues in the regional forensic service have, and it is half the number that our colleagues on the female wards at Mossside Special Hospital have. However, as to the nature of the women whom we are nursing before they go to court, a significant minority of them actually are then placed either to the regional secure unit or to special hospital beds. I think that the point which Dr Faulk has just brought out to you is that we are forced into a position where, if we actually had the nursing:patient ratio, we would not necessarily have to sedate. If it is appropriate to treat somebody in a psychiatric sense, we treat. Often it is the exception for our patients, we find, to refuse treatment. However, what we *do* have to do, which often we do not want to do, is that we have to seclude people far more often than our colleagues working in the NHS do. This then leads, of course, to a situation—which is understandable—that the patients feel more uptight or resentful or frustrated. Then we get into the circular position of management: the more we get into that situation, the more we have to seclude.

Mrs Currie

137. The NHS usually reckons that to have staff on duty round the clock you need five or six people on the payroll for each one person actually on the ward. What you are saying suggests that at any one time you probably have not got more than three

[Mrs Currie *Contd.*]

nursing staff on that ward for more than 30 patients who may well be extremely disturbed or upset or suffering withdrawal symptoms or whatever. Would that be right?

*(*Dr *Hindson.)* In my parent establishment we have a minimum of the principal nursing sister in charge plus five, as our minimum, which has been agreed within the establishment as staff to have available. There are times when we fall below that, but usually we are in the position that we manage between 30 and 34 women, two out of three of whom have some degree of psychiatric disturbance and on whom we are reporting to the courts with six qualified nursing staff, plus a nurse manager.

138. But that must mean, then, to achieve those sort of levels of actual presence in the word, they must be working quite a lot of overtime, would that be right?

*(*Dr *Hindson.)* That is correct, yes.

*(*Dr *Cooper.)* There are occasions as well where we have actually had to close wards because we have not had the requisite number of nursing staff to man them, so this compounds the position where we have an increasing number of difficult people, disturbed people, and because we cannot look after them properly we have had to close down wards, and they are often kept in the main prison or areas which are entirely unsuitable.

Sir David Price

139. Is this acknowledged by the Home Office? Do they accept it? Do they say—"Sorry, lack of funds"?

*(*Dr *Cooper.)* Yes.

Mr Galley

140. Can we move from staffing to the probably even more important topic of pay. The PMA paper states that you regard it as inappropriate that the medical officer class has traditionally been linked to civil service grades. Why do you regard it as being inappropriate, if you are members of the civil service?

*(*Dr *Trafford.)* Simply because there is no comparison whatever in the sort of work that is done. We alone of civil service medical officers are providing a clinical service to our patients quite unlike other civil service medical officers. A mixture of primary medical care and specialist medical care is what we are providing. We are assuming all the responsibilities of the NHS doctor in regard to care of our patients, and of course we are sometimes doing this at a certain amount of risk, both of verbal and physical abuse, and under perhaps one should say threat of legal action and all sorts of things by unwilling patients who resent our trying to help them. We see ourselves as doctors in this respect—not as civil servants—and we like to be treated as doctors. I think that is the position there.

141. But why should you be treated differently, say, from the divisional medical service of the DHSS, who run pretty well a medical service, and they are doing the normal range, often, of a doctor's job?

*(*Dr *Cooper.)* I think we would say that we regard ourselves primarily as clinicians who have to provide a 24 hour service 365 days a year, and we have a clinical responsibility for our patients, a statutory clinical responsibility, which no other governmental medical officer has.

142. What would you advocate instead?

*(*Dr *Cooper.)* One of the areas which we would like to explore is linking our salaries with the NHS grade salaries. I am not saying make them the same, but it would make sense on clinical grounds in that we are doing similar types of work.

*(*Dr *Trafford.)* I agree.

143. Can we go on to the BMA's paper on this topic of pay, where you refer to the absence of merit awards, and you mention the lack of recognition of psychiatric and security stress factors in any of the pay or conditions arrangements. What would you propose?

*(*Sir *Douglas Black.)* I think this is one of the disincentives already touched on by my colleagues, and it obviously has a considerable bearing on the possibilities of recruitment and what we would specifically suggest would be an approach towards clinical salaries in other divisions. I support Dr Trafford's contention that there is not a close analogy between someone doing clinical work directly involved with patients and someone who is not, and this is fairly general throughout the services.

144. Are you looking for something in the way of an additional allowance? If you are on NHS grades, if the prison medical officers are, would you regard that as being

[Mr Galley *Contd.*]

sufficient to take account of the additional stress factors?

*(*Dr *Trafford.)* I do not think we would want to make too much of this, but we would like to be treated the same as other doctors doing perhaps comparable work, shall we say. I would not like to put it stronger than that. I do not think we want to get down to arguing where pounds, shillings and pence per exposure to a dangerous patient apply. We are not trying to argue in those terms. Yes—there *is* a suggestion which has been made, for instance, that we receive payment on the basis of a 42 hour week, the same as the paper-pushing doctors in other departments. We also, as Dr Cooper has said, have to provide cover at night and weekends. There is no additional payment for this, for instance. It is assumed by many prison governors who say "Well, you are a whole time doctor, you are available day and night—the whole time" that whole time medical officer means whole time, and that you are there and available at any moment of the day or night.

Sir David Price: A problem that we, as Members of Parliament, share with you and feel for!

Mr Galley

145. What about the environment allowance which you refer to?

*(*Dr *Trafford.)* We do in fact receive an environment allowance at the moment, which is said to be for working in uncongenial surroundings. I forget quite what the term is. That is a useful little addition. What does it amount to—I think about £30 a month or something like that—so it goes a little way, yes. I do not think it brings us into line, for instance, with the pension arrangements that are available, for instance, to the psychiatrist working in the NHS hospital who, by virtue of the stress of his occupation, is permitted after 20 years service—if he has got 20 years service—to retire at 55 on his full pension. That is not offered to us; or if he stays on after 55 he can count two years for one towards increasing his pension. These are the sort of incentives which are quite considerable and which are denied to us.

146. Are those variations in pensions common throughout the NHS structure?

*(*Dr *Cooper.)* In psychiatry, and of course the ordinary prison officer has the same privilege—he retires at 55 with a two to one pension for every year he serves after 20. If I might go back to what you were saying earlier about salaries and pensions, one of the things may be that the prison medical service ranking ought to be looked at very carefully in that it may be that the medical officers are taking on responsibilities and duties which will be equivalent to a senior medical officer in many other grades, and that the whole grading of the prison medical officer needs to be moved up one. Indeed, the director of the prison medical services is only an SPMO and there are many of us who feel that he should be at least a deputy chief medical officer.

Sir David Price

147. Are any moves being made to have this looked at? Your work as an Association is being presented to the Home Office, is it?

*(*Dr *Trafford.)* This matter of upgrading—starting from the top and moving everybody up one—was to my knowledge brought up through the IPCS channels, the official body, ten years ago, without any result. It was brought up at a meeting which I think Dr Cooper and I attended with the then Chief Medical Officer, Dr Yellowlees, in his day, and it was just received and nodded and yes, that was that. We heard no more of it. We have pursued that one but without any success.

Mr Galley

148. Just to go back briefly to pensions, do the differences between the civil service and NHS pension arrangements cause difficulty with people transferring between one and the other?

*(*Dr *Trafford.)* No. I think broadly one must say "No." A number of us have brought NHS pensions into the civil service with us, and there is not usually any problem with that.

*(*Dr *McErlean.)* Superannuation of part-time medical officers causes some difficulty in that there is no superannuation scheme, and when part-time medical officers provide rather a lot of their time (22 hours of their time) that is not superannuable. This has been the bone of some contention in that there is no security of tenure in the post. There are possibilities of course of taking private plans out for that money, but there is a feeling of lack of security of tenure, which has upset certain people taking long hours in the part-time prison

[Mr Galley *Contd.*]

medical service. In my case, I have taken on another partner in my practice to reduce the practice work to give me the fluidity to do 22 hours work in the prison.

*(*Dr *Hindson.)* I was going to comment about this question about transferring pension rights. As at the moment, anybody who is working in the National Health Service and who has mental health officer status —as applied to myself before February 1982 when I joined the service—as Dr Trafford has already said, it means that after 20 years you would get two for one, so that assuming, for example, that you have mental health officer status from the time you qualify as a doctor, at 55 you would retire on half of your NHS salary. I lost that in 1982. It is something that I thought about before applying to join the service. I certainly know, in the North-West of England, of two psychiatric colleagues who were thinking of applying to join the prison medical service, and the reason why, in the end, they decided not to join is because they would have lost their mental health officer status, so that obviously in the long term it would have significantly affected their pension status.

Sir David Price

149. Can we now come on to a range of questions which we would like to put to you rather loosely as ethical issues? How often are prison doctors faced with ethical dilemmas, as a consequence of their role in prison management? The BMA, in their evidence, come out very much against the involvement of prison doctors in management. Dr Trafford, you have already, in the course of evidence, referred to it. We would like to know precisely why. I think I do know, but I would like to know precisely why.

*(*Dr *Trafford.)* I think you are referring particularly to this question of certification of whether a man is fit for punishment or not. We feel that this is a bad situation for the doctor to be in. If a man breaks prison rules, he is subject to a disciplinary procedure. We feel that the doctor's sole part in this should be to intervene, if we feel that that procedure would be unfair because of the man's inability, as it were, to defend himself because of perhaps his mental state, or if the punishment subsequently awarded was in any way prejudicial to his health, mental or physical. I think we would see this as a matter where we should not be asked to certify a man fit for punishment, which might identify us in the prisoner's eyes with the selection of somebody for punishment, but we should be able to intervene on his behalf, as representing the prisoner, as it were, protecting the prisoner's right, if we feel that this is going to be prejudicial to him in some way. The analogy in the court of law, of course, is that a man is presumed able to defend himself unless he proves otherwise. This, we feel, is sufficient. This is the principle which we understand the Armed Services have now adopted: that a man can appear on a charge and be dealt with, and he is assumed to be in a right state of mind and fit to be dealt with unless proved to the contrary.

Mrs Currie

150. Can I ask how often you are involved in this sort of work where you are having to certify somebody fit for punishment? How often in a typical prison does it happen?

*(*Dr *Trafford.)* In Bristol Prison, once or twice every morning of the week, I suppose. It varies a lot. As for the remand prisons, the female side of our remand centre probably has 25 girls on report per week, something like that. It is a very considerable number. As Dr Hindson said, it is on the female side that intervention is much more frequently necessary. We say "Not fit for adjudication".

*(*Dr *Cooper.)* There is a historical aspect to this, of course, in that a doctor was very much more involved when there was dietary punishment and flogging. Those have gone, but the certification "Dietary punishment" still appears on the form. I would entirely agree with Dr Trafford that, ethically, we as doctors should only intervene on the patient's behalf if we think he is being ill done by, in the sense that he is either unfit for adjudication or that the form of punishment that he is awarded is detrimental to his health. I think that many doctors in the prison service give letters to the governor or reports to the governor or to the Board of Visitors on these lines.

151. What practical difference would it make? What is the difference between your having to see two or three people each morning and reporting on whether they are fit to receive treatment, or whether we were to do as you suggest, which is basically to say that they are all fit not for treatment but fit to receive punishment, but then you intervene in cases where you say that that is

[Mrs Currie *Contd.*]

no longer the case? You would still have to do the examination, and you would still have to make a report. What practical difference would this make?

*(*Dr *Trafford.)* I think that this is seen very differently by the prisoner. If he is brought in before the doctor, just before he is wheeled in front of the governor, and one then asks him what is happening to him or if he understands what is happening to him; if one has to make some sort of conversation with him to assess that he is in his right mind and able to answer the charge against him, we are seen very much as the initial part of the prosecution, in those circumstances. It would be much better if he were able simply to go and present his case to the governor, then subsequently we can look at his record and from our knowledge of him, or even at the governor's request, we can say, "We'd better have a careful look at this man." Then he would be seeing that we were intervening on his behalf. After all, the patient should be our first concern, not the Home Office.

152. Following on from what you say, in paragraph III.4 of the PMA memorandum it does say that there should be a medical contribution to prison management, but that this should be at the Home Office and not at the local level. All the description that we have just had from you is entirely based on local decision-making, decision-making actually at the point of being in the governor's office or in the prison hospital and deciding whether a prisoner is fit or not. Are not you concerned that if the Home Office did take on more of the management responsibility, your ability to make local decisions and to take local circumstances into account would be diminished?

*(*Dr *Trafford.)* I think that what we meant this to mean was that there must be an underlying medical input into the whole regime and management of prisons, because we know that prisons are going to deal with people who come in all shapes and sizes, and with all sorts of disabilities, mental and physical. There is the extent to which the individual medical officer can use his discretion. He cannot really lay down his own rules for the way the prison should be run locally; this has got to be an established regime with a definite medical input into it. However, I think that the doctor locally should be an adviser only and should be able, as I have suggested in the case of disciplinary matters, to intervene on behalf of the patient. He should also be able, in my opinion, to intervene in matters of hygiene. When the staffing levels fall too low and there are no officers to man the bath-house, the prison doctor should be able to step in and say, "This isn't good enough, something's got to be done about this." We can say it, but we are talking to the wall very often, I am afraid. I think that that is not putting it too strongly. The general matters of hygiene within the prison have been reiterated for so long—the slopping out, the absence of washbasins and all this sort of thing—that these conditions have come to be accepted. I think that if we were seen in some way as advisers, not as part of the management, it would help. It should not just be said, "Well, you've tolerated this for X number of years." This is the curious thing we get. I have known the case with the Board of Visitors where, when I have made a fuss about this, the Chairman of the Board of Visitors has said, "Well, there hasn't been any plumbing hitch, it hasn't changed in the last 20 years."

Mrs Short

153. Twenty? One hundred!

*(*Dr *Trafford.)* So I said "Well, so what—this is the way it was built in 1883, but we are now in 1983 and I felt it was time it should be changed" But the Chairman could not see this, and said "Well, this has been all right".

154. What do you tell the Home Office about these appalling conditions? Slopping out is horrendous. I have been present at slopping out exercise in one prison.

*(*Dr *Trafford.)* This goes on our hygiene report.

*(*Dr *Cooper.)* We can report it, but the problem is there are no minimum standards that we can refer to. They always say "Well, it was worse five years ago". You see, there are no minimum standards laid down in prisons as regards overcrowding, the number of toilets, the amount of living space, the quality of medical care or anything, so we are really working against a background which is elastic and can be manipulated according to the number of people you have in the system.

Sir David Price

155. So you have nothing like the Health and Safety at Work regulations?

*(*Dr *Cooper.)* No.

Mrs Short

156. But surely through your organisation, and through the BMA and the other medical organisations involved you ccan make representations to the Department and say "Look, really in this day and age it is time this ceased, and we ought to have better conditions—at least modern sanitation"? Three in a cell is bad enough, but when you have got to slop out and all these long lines of men have to wait with their chamber pots to tip them out into a sink on the landing, it is horrendous—dreadful for morale—so what are you saying to the Home Office about it, and if not, why not?

*(*Dr *Trafford.)* Well, first of all, as I think we made clear in our report at the beginning, we have to operate under the regimes which the Home Office impose upon us. Regimes are not designed by the doctors, let us make that clear. We are not responsible for the regimes and we have tried very hard most of us I am sure to try and get these things changed.

*(*Sir *Douglas Black.)* I think prison medical officers are in some difficulty because they are employees of the Home Office, and after a lot of consideration we think that that should persist, but nevertheless we do recognise that the Home Office is not enthusiastic over accepting criticism from employees, and earlier Dr Trafford mentioned a specific instance of that. From the BMA point of view, we of course are responsible to some extent for that, I think, quite excellent little book that Richard Smith published on this, and one thing that comes out very clearly to me from that is that while there are imperfections in the prison medical service, which need remedy and which we have made suggestions about, the overwhelming thing is the grotesque state of overcrowding in the prisons which has brought so many of these problems to a head. I sometimes trespass outside the medical field and usually I regret it, but it seems to me, if longer and more numerous prison sentences are a panacea for all our social ills, it is slightly unfair to blame the medical service for it, if I may say so, with no emotional tone whatsoever.

Mrs Currie

157. To what extent is your desire to be relieved of managerial responsibilities within prison a desire also to be absolved of any responsibility for the appalling conditions which you are prepared to put up with?

*(*Dr *Cooper.)* I think what we *would* like is to be able to do something. It is rather frustrating if we make all the recommendations in the world and nothing happens. I think what we are talking about and what Sir Douglas was talking about earlier about having access to outside bodies who report and look at things are matters that would aid us very much along these lines.

Sir David Price

158. Following that up, does it not tie up with the discussion we were having rather earlier about the possible need for an improved inspectorate? If we take the whole of the prison inspectorate, a far bigger medical and now we are saying hygienic element has to be in it for it to be effective. You were talking about only being visited once in every 5 years.

*(*Dr *Faulk.)* I am made anxious by your remark, because I feel that you are suggesting that the Home Office inspectorate would be somehow enlarged. I think the inspectorate we are proposing—well, "inspectorate" is the wrong word—the advisory service, if you like, we are proposing that it should be ex-Home Office, because if it is within the Home Office we know from the report by Dr Lee, I think it was in the Lancet, that it will get nowhere. It will just disappear within, but if you have I think an outside approval body, or whatever, that should be by rights allowed to make public its findings. I think public opinion should be the pressure.

Sir David Price: Good.

Mr Galley

159. Can we turn to other ethical issues? What about hunger strikers and the present arrangements? Are they adequate?

*(*Dr *Trafford.)* Basically, yes, I think so. We have adopted a plan now which I expect you are familiar with, and this in general does not produce grave problems to us. I know there have been particularly difficult cases, those in Northern Ireland have raised some very unpleasant problems, but a policy has been adopted on this, and the hunger strikers that we normally see now are pure manipulations. We see these constantly to some extent. There is always one or every few months we get one cropping up where prisoners will try to use the hunger

[Mr Galley *Contd.*]

strike weapon as a method of manipulation and this is usually a short lived protest.

160. Do you always need an outside consultant as a matter of course to be involved?

*(*Dr *Trafford.)* Well, we try, yes, to get an outside consultant in very early. We have to by standing orders, I am reminded from my left, but this is plain common sense. We do merely to show that an outside, an independent doctor, has been involved also.

161. What about consent to treatment? What are the current arrangements about prisoners' consent to treatment, and under what circumstances would treatment be given without consent?

*(*Dr *Cooper.)* Consent to treatment is a difficult subject within the prison service, because we are always open to the charge that we are bringing coercion to bear on anybody by promising the earth or threatening them, but we would only give treatment against the will if the patient was acutely homicidal, suicidal, or was in danger of deterioration through a mental disturbance. That would be a generally one-off situation. There is no place in the prison service for a planned course of treatment over a period of time for treatment against the will, so what we are talking about is an emergency situation to protect others, to protect the man from himself, and to protect the individual from irreversible deterioration, and that is done under the auspices of the common law. We have no protection from the Mental Health Act, because we are not recognised as hospitals. Now, there is a very difficult and ethical problem which arises here. If a man is acutely mentally ill, and we have to treat him against his will, that gets us over the emergency, but often the mental illness carries on and he requires further treatment. It will be very helpful to us in the prison situation if the NHS could take these people off our hands very quickly. Often we see people deteriorating and it is very difficult, because we cannot get these emergency cases away. That makes it very difficult—the man is refusing treatment and deteriorating and we cannot get him into hospital.

Mrs Short

162. Could I ask if a prisoner could make an allegation of assault against a doctor who compelled a the prisoner to receive treatment if he had refused it?

*(*Dr *Trafford.)* He could *make* the allegation, yes.

163. To whom would he make the allegation?

*(*Dr *Trafford.)* He can complain through the Board of Visitors. He can write to his Member of Parliament. He can petition the Home Secretary about it.

164. Are those allegations very often made, in your experience, do you know, either through your Association or personally?

*(*Dr *Trafford.)* No, I do not know of one, actually. We rely there on the defence of the common law, that we have in fact undertaken this treatment for the man's own benefit. We will try to get an independent opinion in support of giving such treatment. However, as Dr Cooper has said, the mere acuteness of the situation sometimes makes this impossible. If we can, we would get an outside consultant in. He will write then in the case notes: "This man requires so-and-so." We will then proceed and treat, if necessary.

Mr Galley

165. Are the circumstances sometimes so acute that drugs may be administered without a doctor consenting and being present, against the prisoner's will?

*(*Dr *Cooper.)* I would say, not in the prison service, no. I think that a prison hospital officer would lose his job if he did that these days.

*(*Sir *Douglas Black.)* I think it is relevant to Mrs Short's original question to say that Dr Faulk has analysed the letters sent to the BMA of allegations in the last three years.

Mrs Short

166. You had a whole pile. I had copies of them sent. That is why I asked.

*(*Dr *Trafford.)* A small pile!

*(*Sir *Douglas Black.)* The particular allegation to which you referred, of treatment without consent, did not figure among them. I think that is correct.

*(*Dr *Faulk.)* That is correct. There has certainly been one case that we know of which reached the High Court, where a man alleged that he had been treated with drugs against his will. However, in those

[Mrs Short *Contd.*]

complaints I do not know of, and do not recall, one of a similar nature.

(Sir Douglas Black.) They were not tremendously numerous, but one's definition of "numerous" depends on how one is viewing the matter.

Mr Lewis

167. Turning to the prison hospitals, in the PMA's paper you state that a case can be argued for a centralisation of specialist hospital units in regional hospitals, serving groups of satellite establishments. Would you say that there are any prison hospitals suitable for this role?

(Dr Trafford.) As they are at the moment, I think, there are probably very few. They would need to be redesigned and enlarged to serve this purpose.

168. So it is a non-runner to start off with, under the present system?

(Dr Trafford.) It is under the present system, because no matter what suggestion is put forward, we are just told, "There's no money", finish, and "Get on with it."

169. It is something you would like to see?

(Dr Trafford.) Yes. Each senior medical officer is responsible for a few smaller establishments often manned only by a part-time medical officer. If he gets an acute psychiatric problem or something of that sort, he would like to pass it on to us. Sometimes we have to refuse him, because our hospital is already full up with our own problems. It is necessary then for him to contact his local psychiatrist and see whether he can arrange something in the local hospital instead of in the prison.

170. In paragraph V.3 of your paper you say that the appointment of civilian hospital managers in prisons might be considered to enable officers to give more time to nursing duties. Do you know if any steps have been taken yet in this direction?

(Dr Trafford.) No.

171. Or is anything likely to take place in the future?

(Dr Trafford.) No, I am not aware of *any* step in that direction.

172. Would you say that the present arrangements in the hospitals for X-ray facilities are adequate? Is the training in radiography, given to some hospital officers, adequate, or would you like to see much more done in that particular field?

(Dr Trafford.) I do not think this is a very profitable area for pursuing for big increases. On the whole, this part of the service is adequate for what it does. I would not put it higher than saying that mostly this is a matter of screening minor injuries, to make sure that we are not going to waste escort time and so on taking a man out to an outside hospital. I would not like to make too much of a point on that.

Mr Lewis: Thank you.

Sir David Price

173. Would you like to see any of your hospitals designated under the Mental Health Act? This ties up with our earlier discussion.

(Dr Trafford.) I think that this would be inconsistent with the philosophy that we are working under that the mentally ill should be treated in a hospital and not a prison. I do not think it would really improve the lot of the patient very much. I think it would be very marginally of benefit to the patient.

Mr Galley

174. The position with regard to medical records does seem to be rather chaotic. The PMA say in their paper that the initial medical examinations are too hurried, and that the information obtained is valueless. Why is that? Surely it would be a very easy matter to sort out?

(Dr Trafford.) Yes. Time is the answer here. I do not want to sound too trite, but this calls for a visit to Brixton Prison on a Friday night, at about 9 o'clock in the evening, when there may be 70 or 80 new receptions coming in, when the police cells are being cleared out before the weekend, and the staff are all anxious to get away, as is the doctor who happens to be on duty. To take medical histories and conduct full examinations of that number of patients really is an almost impossible task.

175. Presumably it has to be done at the point of reception, otherwise the value of it is reduced?

(Dr Trafford.) Standing orders require that it should be done within 24 hours of reception. It is very difficult to fit it into the prison routine, because again it needs a lot of officers moving bodies about within the prison and bringing them to the doctor. I think all of us have found this: that new

[Mr Galley *Contd.*]

receptions who miss the doctor overnight are an embarassment in the morning to everybody, because arrangements have to be made to find staff to escort them and so on. It is a very important point. I believe this is the most important medical examination that happens, and it is very unfortunate that by the mere facts of life as they are, it does happen at a time which involves staff working at unsociable hours. It is very difficult to get round this one. We have given a lot of thought to this. Unfortunately, too, unless this interview is conducted with a fair amount of time and relaxation, the information disclosed by the patient is often so limited and of such little value.

176. So it could actually result in adverse effects on the care of the patient whilst in prison?

*(*Dr *Trafford.)* Yes. It depends on the extent to which the prisoner newly arrived in prison is motivated to co-operate with anybody. He may not be motivated even to co-operate with the doctor. That is why he will withhold vital information. He may well not be registered with a doctor outside, so that it is extremely difficult, unless he gives us the clues, for us to follow up his medical history.

Mr Favell

177. Is there a case for extending the 24-hour rule?

*(*Dr *Trafford.)* I do not think so. I think I would like to stick with that, because these men are supposed to be kept separated from the rest of the prison population. This is from the point of view of inspection particularly, in that they have got to be screened to some extent before they can be put into the system. No, I think it has got to be done, but there are real difficulties in getting doctors who are prepared to work in the evening to see receptions (which is not a very rewarding and pleasant task always), and, indeed, to keep the staff on late to man the reception is even difficult, I believe, in some prisons.

178. Obviously you agree that computerisation is something which must come and come quickly?

*(*Dr *Trafford.)* Well, I think this is essential, because so much of our ferreting out information about patients is very time-consuming. We get a lot of inquiries returned from hospitals the other end of the country, saying "Not known" or something and then you find a different name was being used at that time, and there are so many problems in getting the information that having once extracted it it is so unfortunate that all this goes into his medical case notes, he then gets transferred to another prison, then he is discharged from prison and the next time round he comes into prison and you start the whole process again, because it is difficult to track down his original case paper.

179. Have either the PMA or the BMA carried out any studies into the best form of computerisation, or how best this problem can be tackled?

*(*Dr *Trafford.)* Not to my knowledge.

180. Are there any proposals to do that?

*(*Dr *Cooper.)* Not as regards medical records. As regards ordinary prison records, I think there are pilot studies afoot. Probably one is starting at Oxford, but I do not know of any regarding medical records.

181. Clearly you think it is a good idea for something to be done now?

*(*Dr *Cooper.)* Yes, very much so.

182. What efforts do you make to get hold of the records from the GPs, or the NHS record when they first arrive?

*(*Dr *Trafford.)* By letter or by telephone. If a man comes in and says he is receiving treatment of so and so, sometimes he knows what he is taking, sometimes he produces a few bottles from his pocket and can show you what he is taking—that is often more reliable than what he tells you, provided his own name is on the bottle—and otherwise we phone up his GP, but even there we have difficulties, because he says "Well, I got this this morning from a GP in such and such a town or village. I am not actually registered there but I was just passing through" so immediately one is put against this difficulty of records, and one sometimes has to phone chemists to check up on where drugs have come from. We have a standard form which we send out giving the patient's consent to disclosure of information signed by him in the presence of a witness. We use this as well. That form usually produces a rather slow response from hospitals. It is much better, I find, if one possibly can, to discover the name of a consultant and send it with a personal note. That usually achieves much more.

[Mr Favell *Contd.*]

183. What about the record which you have got together whilst a prisoner is serving a sentence? How often are you asked for that by a GP elsewhere?

*(*Dr *Trafford.)* A certain number of times. Dr Cooper on my left whispers "Quite often"! I would not have put it as high as that. It is variable. We are asked on occasions because people go on having treatment. We endeavour to see every man being discharged—in fact every man being discharged is required to be examined before release, so that if a man is on treatment, we ask him then "Are you receiving treatment now?" and if he is we try to send a note to his doctor. Sometimes this will go by post. Sometimes he does not know the doctor and we have to give him a note addressed "To the Doctor concerned" and I do not know what happens to that note. Sometimes we get some phone calls after a man has left us either saying "What are you doing prescribing X, Y and Z for this man?" and we look up his record and find we have not supplied him with anything. Of course, this is open to so much abuse, but there *is* an exchange of information, and we *are* accessible, and we welcome this from the GP or from the hospital outside.

*(*Dr *Cooper.)* It depends of course how long the man has spent in prison. Some of my patients have been in prison for 15 or 20 years. Obviously the situation there is different from a man who has only been in three weeks. In many cases, the longer serving prisoners actually have to be found a GP through the probation service known to the area in which he is going to live.

*(*Dr *McErlean.)* I have life sentence prisoners only, so I have got the GP records so the patient goes out, registers with a GP, and then the records go back to Southport, and then they eventually get to the GP he is registered with, which is a very lengthy procedure. General practitioner notes moving around is a very very slow process.

184. Finally, what about the habitual offender? How easy is it to get hold of the medical record from his last sentence when he serves the following one?

*(*Dr *Trafford.)* It is surprisingly difficult. It sounds simple. I have never discovered why it is so difficult.

185. If a prisoner has suffered from a severe psychiatric disorder during the time of his last sentence, which he may have only finished serving two or three months before it is pretty important that you know immediately about this kind of condition, is it not?

*(*Dr *Trafford.)* Indeed.

*(*Dr *McErlean.)* Every prison they are in tends to keep their own hospital case papers, and it means ringing up several different prisons.

186. Is there not a case for storing these case records centrally?

*(*Dr *McErlean.)* Well, your computer would do that.

*(*Dr *Cooper.)* It is not only a question of storing them centrally—it is having access to them quickly. Storing them centrally in a warehouse would be no good, because we are talking about literally 500,000 receptions a year in the country and it is an enormous number.

*(*Dr *McErlean.)* GP records are kept centrally and that is a hopeless situation.*

*(*Dr *Trafford.)* Even local records may not be accessible at the time a reception is seen. You see, in the evening they are not available and over the weekend they are not available, because the records will not be accessible.

187. I had a case recently where there was a prisoner who was released and having had no psychiatric treatment during one particular sentence, it came as a surprise to the medical service that he had had a very severe psychiatric problem during his previous sentence. Quite obviously they had never even seen his records which certainly concerned me in view of the crime which he subsequently committed.

*(*Dr *Trafford.)* This is one where presumably he had good reason not to disclose his entire history when he came in. This is a very real problem, yes.

Mrs Currie

188. Can I just ask this, on patients of that kind: you did mention earlier that you believe psychiatric patients should be treated in a hospital and not in a prison. Are you actually finding it easier to arrange that kind of transfer? What sort of length of time does it take, or in fact are you finding that your colleagues in the NHS believe that if

* *Note by witness:* I am referring here to the length of time elapsing before records are produced for a patient's new general practitioner.

hey are psychiatrically disturbed and dan-gerous, they ought to be with you?

*(*Dr *Cooper.)* If I can talk about long term entence, and the more difficult ones, the novement of such people to the special ıospitals has improved. They do not take ong—on the whole we are talking about hree or four weeks, except in certain solated instances. The problem arises in getting people who are a little difficult and ıot quite as dangerous to qualify for a pecial hospital. The regional secure units vill not take them, because they require nore than 18 months' treatment or they are ıot likely to get better in 18 months—in ther words, the chronic schizophrenic and he person who goes on and on requiring reatment and support. Those are practi-ally impossible to get into anywhere, and ve are talking of submitting section 47 orms. It is that particular group of people vho I find are very difficult to fit into the NHS.

*(*Dr *Trafford.)* Yes. It is the patients equiring long term care, I think—not ıecessarily cure but care. These are the ıost difficult ones.

*(*Dr *Hindson.)* Following on those com-ıents, working in a remand situation as I o, when we run into difficulties with omebody being acutely mentally disturbed vhile they are on remand, and before they ave been dealt with at court, we in fact ransfer out to colleagues in the regional orensic service or even transfers under the ew section 35, section 36, section 38 even o the special hospitals and the liaison with ur colleagues in the north west, works very ell. However, when I look back to ten ears ago, when I was working in the north est of England as a psychiatric registrar, ıere was a small population of women, vhom we all know—and by "we" I mean ıe psychiatrists in the cities of Liverpool nd Manchester—and ten years ago these omen were actually existing in the old yle psychiatric hospitals for given periods f time. Now, these people are no longer dmitted to psychiatric hospitals, and what happening particularly with women artly because we deal with the women for ıe north region) is that we can see an lentifiable population of women who go to ıe courts. There is no longer the case that ıey will be admitted in to psychiatric ospitals. It may not be possible to put ıything together in the community and ıey are actually then going short term into ıe female prison system, out from sen-tence, back into the situation, back to us on remand, and so it goes on.

Sir David Price

189. That is very interesting. As to the first part of the proposition, are you content with the numbers being sent for medical and psychiatric reports in the first instance? Do you feel that there are too many coming to you, and that they should really have been dealt with within the medical service?

*(*Dr *Hindson.)* I have only been in the service for just short of four years, but as far as I am aware in terms of the remand situation in the North Region, the actual numbers of reports that we are being asked for are falling, and the numbers of medical reports on remand being dealt with are falling. However, even with the new provisions, the people off the streets, if you like, who go to court would still come to us in the first instance anyway, even with the new provisions under the 1983 Act, as the PMA has said in its evidence. Secondly, there is the volume of reports that are asked for by NHS colleagues, by the regional forensic colleagues in the NHS covering their regions. They would not be able to cope with the volume required. So it is very much a case now of the fact that we work together. For example, *we* cover the City of Manchester and so do our regional forensic colleagues. Therefore, at times, the magistrates court administrators phone up and say, "Dr Hindson, do you want to do this one this week? How are you in terms of beds, or should they go to the regional forensic team?" It is necessary, to provide the service to the patients, to build up that sort of liaison.

Mr Lewis

190. Why do you think the experiment in psychiatric posts held jointly between the PMS and the NHS was unsatisfactory, according to your paper here? Would you like to see further developments along those lines?

*(*Sir *Douglas Black.)* This has been very unsuccessful.

*(*Dr *Faulk.)* I was one of the very early joint appointments which was unsuccessful.

191. What would you like to see done, then?

*(*Dr *Faulk.)* When they were set up, they were set up following a working party in 1964. The belief in 1964 was that they needed more psychiatrists in prison, and

[Mr Lewis *Contd.*]

they were not attracting them. They thought that to get them into prison they could make an attractive post which was half in the prison and half out. I was the sixth such appointment. When we came in we thought that our task was in fact to introduce psychiatric methods into the prison hospital. The people who worked in the prison—the prison doctors—at that time did not see that; they wanted someone to relieve them of psychiatric patients. It was quite a different perception of the posts. They did not want an outsider coming in and telling them how to do their job. So there was an immediate clash, and that was never resolved.

*(*Sir *Douglas Black.)* It sounds to me as if it is potentially resolvable, however, given a different reconsideration.

*(*Dr *Faulk.)* I do not know that it is so necessarily. Perhaps I have been too badly burnt by it, but I do not think that it is needed in that original sense, or at least I do not think the prison service wants it in the original sense in which it was conceived. There is already enough expertise going in for diagnostic purposes. The Home Office —perhaps quite properly—does not wish to develop the treatment facility within the prison to which the outside psychiatrists could contribute. Its wish primarily is to diagnose and transfer as soon as possible. The diagnosis side is done very well at the moment. The problem is what to do with the patient once you have diagnosed him. To provide an immediate service as is required, would require considerable expansion of the NHS services. That is not just in regional secure units. They have been conceived of as relatively small units. It would have to be in the catchment area services. I did a survey of the way court cases went. First of all, the numbers are much smaller than everyone expects. In Wessex, which is 2½ million people, there were only 16 cases of people whom the court thought sufficiently mentally ill to send to hospital, in a year. Of those, two went to special hospital, three came to the regional secure unit, and 11 were distributed amongst the catchment area hospitals.* That is where you have got a regional secure unit which is working, you have got enough beds. It leaves the catchment area hospital currently as providing the biggest difficulty, according to my own study.

192. Dr Cooper, have you anything to add to that?

*(*Dr *Cooper.)* Yes. I have worked with Malcolm Faulk for more years than I care to remember! I think that one of the problems we saw in the prison service is that we expected the new joint appointments to deliver the goods in the shape that they were going to take psychotic patients off our hands. In many instances, of course, they had no facilities, no beds, which the regional secure units were very slow in developing. So we had people advising what to do with psychotic patients, but no means of implementing their decisions. I think this led to a certain amount of friction and disillusionment. However, I would agree with Malcolm that I think that the present situation, where they *are* separate, in some ways is a good one, providing the regional forensic psychiatrist can provide a service for, first of all, our psychotic patients within a prison setting, and secondly, provide a means of liaison when those patients are eventually introduced back into the community. It must be remembered that we have a lot of patients in the prison system who are schizophrenic but still under treatment. People say to us, "What are you doing with schizophrenics?". If a schizophrenic is under treatment and is perfectly all right, but he has committed an offence, where do you send him? He comes into prison on treatment. That is one of the dilemmas that we have. This is where I think the forensic psychiatrists could help us in their aftercare and follow-up of these people.

Mrs Short

193. What about the special problems—the psychiatric problems—of women? I know we have touched on women in prison. They tend to be sent to Holloway mostly, do they not? Are there any women psychiatrists working in the prison service, for example, to whom women prisoners might relate more easily, bearing in mind that when women are put in prison, if they have got a family and a home, they have particular stress that perhaps the men do not experience? They are worried about their children and what is happening to them. If they have got small babies, the babies are with them for a time. That can be very stressful, and it can be

* *Note by witness:* For a good NHS Service there must be appropriate beds in Special Hospitals, Regional Secure Units and the catchment area hospitals. My own inquiries suggest that the latter may present the most difficulty in the long run.

[Mrs Short *Contd.*]

even more stressful when their babies reach a certain age and they are taken away from them and put into care. I think there are a special whole group of problems affecting women prisoners.

*(*Dr *Trafford.)* From the prison point of view, one must not make this problem bigger than it is. My personal experience down in Bristol is that our catchment area for women covers about a quarter of England and Wales—South Wales and South-West England. That extends from Aberystwyth to Birmingham to Bournemouth and everything in that bottom left-hand corner. In the last five years we have not had a single patient with a baby coming into custody in that time.

194. You are lucky. Holloway gets them!

*(*Dr *Trafford.)* It does happen, yes, but the number must be very small, even at Holloway.

195. Yes, it is small. Fortunately, the number of women prisoners is small. Women are more law-abiding than men, they are put into prison less often. Still, though, it is a problem. I think that we cannot push it on one side. It is a problem for those women who are put in prison and are separated from their families, is it not?

*(*Dr *Trafford.)* Yes. As to the provision of lady psychiatrists, we certainly have some in the service who are wholetime prison medical officers with psychiatric qualifications and experience. I would not like to guess at the number. We have one in Bristol. There is one in Cardiff, I know. There are certainly two I can think of at Brixton, I believe.

*(*Dr *Faulk.)* I think you might be jumping to conclusions if you assume that a women psychiatrist is necessarily better with women than men.

196. I am always willing to stand up for my sex, where ever possible!

*(*Dr *Hindson.)* Whilst in terms of numbers Holloway is certainly the biggest single female establishment, and in terms of numbers of women going on remand it is, if you like, equivalent to Brixton. Within the north region the second largest female establishment in terms of remand is Risley, and of the three satellite establishments that are covered by the medical staff from Risley, two of them are women's prisons, Styal closed women's prison and Drake Hall open women's prison, so in terms of the numbers of women within the system, after Holloway and Bullwood Hall, there are the three establishments in the north west that come together under the same medical cover, and form the second largest concentration of women prisoners in the system.

Mr Galley

197. We keep hearing all sorts of horrific predictions about the cumulative accelerating growth of Acquired Immune Deficiency Syndrome, and perhaps some of the most dramatic of those are about growth in prisons. Is this alarmist nonsense, or is it right, and if so, are we going to be able to cope?

*(*Sir *Douglas Black.)* I would say it was neither. There is so little actual knowledge about AIDS that it leaves tremendously wide range for speculation. I think obviously there are factors like the incidence of homosexuality which might make prison populations more vulnerable, and I think a number of AIDS transmissions are related to blood transfusions and the like. The BMA is actively making statements about it, but the trouble is such statements tend to change every month or so as, happily, new knowledge comes forward. I think it is nearer being an alarmist statement than it is to being a statement of fact, which was I think your second alternative.

198. But if there is a growing problem, or likely to be a growing problem, have we in the prisons the isolation services, the laboratory services, and all the other services that may be required to cope with a growth in infectious disease of this kind?

*(*Dr *Trafford.)* The laboratory services for this particular problem are extremely specialised, and I think it would be very unwise to try to set up our own service.

*(*Sir *Douglas Black.)* This would be a matter of sending out for laboratory facilities to the Public Health Laboratory Service, whose salvation I was delighted to see, incidentally, and also of course the NHS labs as well, especially research labs, in St Mary's Hospital and elsewhere.

Mr Lewis

199. You advocate an extensive health education programme among inmates. Do you envisage that this should be carried out by hospital officers appropriately trained or by others?

*(*Dr *Trafford.)* It could be done. I think this calls for mixtures. We see very many young people in custody who are very

[Mr Lewis *Contd.*]

ignorant of healthy ways of living. I think they would all benefit from some very serious guidance on such matters as eating, smoking, drinking, drugs, sexual activity and so on. I think these are all areas in which factual explanations and guidance could be given and those could be given sometimes by doctors, sometimes by trained nurses, sometimes by hospital officers, sometimes by the education department—but I think it is an opportunity for an education in healthier living which sadly is not being utilised at the moment. I would personally like to see this made use of.

200. Has any programme actually been established in any prison at all, whose progress could be monitored?

*(*Dr *Trafford.)* I do not know of one. I do not doubt there have been sporadic lectures but I would not put it stronger than that.

Mrs Short

201. Is that not a role that perhaps some of the general practitioners who do part-time work in the prison service could help with?

*(*Dr *McErlean.)* I have given certain first aid lectures to a number of the prisoners within Kingston Prison on an informal basis. They are very interested in physical culture. Prisoners being in for a long time get very interested in physical culture and they do frequently come to discuss things on an individual basis—some aspect of health care or other. There is no planned system, but it is an *ad hoc* system.

202. I suppose it is really left to the individual doctor, is it not? If he feels enthusiastic enough he can do that?

*(*Dr *McErlean.)* Yes.

203. But I would have thought the whole area of addiction, whether it is to drugs or alcohol, and sexual problems, would be very fruitful as an area?

*(*Dr *McErlean.)* This is very important of course. One discusses this with the individual, because many of them have come into prison, and many of them killed, because of their inebriated state at the time, and one constantly advises them of the problems of alcohol and the problems of drugs. The drug aspect—and I might be in a fool's paradise on this—I think is something which most of my long term prisoners have gone through; the alcohol regrettably is slightly different, and the chaps still brew their hooch up and we do still find a certain amount in the chapel at Christmas time and such like being brewed up. We do have opportunities in small units of discussing people's health problems in some depth. For example, yesterday I was discussing in some depth one of my prisoners wanting to know about porphyria, because he had wanted a family, and one had a long discussion on that—having read it up first!.

204. On our visits actually that we have made to prisons so far, I think the problem of resources has been brought to our attention. You are not really in a position to take on the full commitments of staff that you ought to have to provide that sort of one-to-one or one-to-two or three help and guidance that many prisoners are actually in need of, and have said so to us, so that is a problem at the present time, is it not?

*(*Dr *McErlean.)* The prisons are very different. My prison being small with long term people is a prison where you know them much more as individuals, whereas the remand where there is rush and pressure all the time is different. One can do things in a more couth manner with a long term prisoner.

*(*Dr *Cooper.)* This is an area where one can involve the ordinary officer. I think he is probably the single most important figure in relating to the inmates in many ways, but if you are going to have a programme like this, it must be of sufficient quality and you must be able to guarantee it. There is nothing worse than stopping or starting and this comes down to resources, and this is where so many of them have failed.

205. Of course, you have your chaps for a long time.

*(*Dr *Cooper.)* We have a captive audience, yes!

*(*Dr *Trafford.)* It is very easy to live in a fool's paradise and believe that everybody with a drink or drug problem is anxious to do something about it, because sadly they are not. We can recognise and we can point it out, but they do not want to recognise it sometimes—in fact, very often.

Sir David Price.

206. On the specific problem of drugs which we have just touched on just now; we have heard the view expressed that prisoners who are drug addicts are not properly

[Sir David Price *Contd.*]

treated while in prison, and you state you do not believe this to be true. You can say that with total conviction can you?

*(*Dr *Trafford.)* With some feeling, yes.

207. You feel this is a false impression?

*(*Dr *Trafford.)* I think this is a false impression. We do honestly try to help these people to get away from their physical addiction along the ordinary accepted lines of treatment, yes.

208. Sir Douglas, the BMA in its evidence at paragraph 6.10 of its paper suggests that the incidence of drug abuse in prisons is increasing.

*(*Sir *Douglas Black.)* I think the accepted methods of treatment have been deployed. Of course, the unfortunate thing is that accepted methods of treatment are not necessarily effective. I think it is difficult to get concrete evidence, and I think we may have gone out on something of a limb in saying that the incidence was increasing, but there is a general climate of opinion, surely, that both inside and outside prisons, incidences of drug addiction are increasing?

209. Certainly when we were doing our drugs report a year ago, there was the impression given to us by some of the witnesses that people did not find it too difficult to get drugs in prison. I am not sure of the problem as regards medical officers.

*(*Dr *Trafford.)* No, but we become aware of effects sometimes that suggest that drugs have been brought in, and it is very difficult to get hard facts on this.

210. Would this also be right? Again, an impression was given that often a drug abuser was only identified when he was on remand? I have had that in my own part of the world, that that is the only point at which it becomes clear to anyone "in authority", when the person is on remand and under medical examination. Is that correct?

*(*Dr *Trafford.)* Yes. This is a factor which is usually discovered in the first few days. Suspicion may be aroused on the very first interview. Usually it is a matter where, within 24 or 48 hours of his arriving in prison, we have got a pretty shrewd idea what is going on. Thereafter, the course that he takes depends upon how long. All we can do during the remand period is physically withdraw him slowly, in an appropriate manner, then we really wait until his case is dealt with. We are not going to embark upon very much more at that stage, until we know whether he is going to be with us or not, but we will try to steer him in the direction and advise him to go in the right direction. Of course, if it is only a short remand, he has only been off it perhaps for a week. Then he goes to court, and we suddenly find he has been bailed, or something like that.

Mr Lewis

211. Dr Trafford, with your long experience of medical aspects of the prison service, what one recommendation would you like to see this Committee come forward with? Do not answer it if you do not want to!

*(*Sir *Douglas Black.)* I could make one without long experience, and it would be to have fewer prisoners.

212. I would accept that.

*(*Mr *Hindson.)* Give us more nursing staff.

213. However, we have got to face the world as it is, have we not?

*(*Sir *Douglas Black.)* Yes.

Sir David Price

214. More nursing staff?

*(*Dr *Cooper.)* Better trained nursing staff.

*(*Dr *Trafford.)* More nursing staff and a higher standard of training is, I think, probably one of the most important things.

215. Also longer-term better prison facilities generally?

*(*Dr *Trafford.)* And the general improvement of the physical conditions.

Mrs Short

216. No more slopping out?

*(*Dr *Trafford.)* Yes.

Sir David Price: Sir Douglas, Dr Trafford, gentlemen, thank you very much. We have had a very good two-hour session. I do not think we can detain you any longer. Thank you very much for your written evidence, but particularly for coming and giving us such clear evidence.

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HOUSE OF COMMONS

SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

Wednesday 4 December 1985

Royal College of Psychiatrists

Dr T H Bewley, Dr P Bowden and Dr H Rollin

Royal College of General Practitioners

Dr E Martin and Dr D Jolliffe

Royal College of Nursing

Mr P Mellor and Mr M Brown

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WEDNESDAY 4 DECEMBER 1985

Members present:

Mrs Renée Short, in the Chair

Mrs Edwina Currie
Mr Tony Favell
Mr Roy Galley
Mr Ron Lewis
Sir David Price
Rev Martin Smyth
Mr Nicholas Winterton

Memorandum submitted by the Royal College of Psychiatrists

SUMMARY

1. The Home Office should recognise that both administering a system of punishmen and at the same time procuring the health of those being punished are incompatibl objectives.

2. The Prison Medical Service should be managed by a single body. Whether by a Join DHSS/Home Office Board or singly by the DHSS there would be less conflict of roles fo prison doctors.

3. It is necessary to introduce a training grade into the Prison Medical Service and t allow doctors to work part-time outside if high calibre staff are to be recruited.

4. Prison doctors have no time or encouragement to continue their medical education They do not undertake research and outsiders are discouraged from doing so.

5. There is an urgent need to provide guidelines on Consent to Treatment in prisons which are at least equivalent to those in the NHS.

6. The development of special units in prisons recognises the inevitability that mentally disordered offenders will be imprisoned and require treatment.

7. Historically, the prison medical officer's role has developed into that of a referee who could be relied on to support the home team. The prison doctor's role outside the provision of health care needs reviewing.

1. Expansion a Central Issue

1.1 In 1979, the Committee of Inquiry into the UK Prison Services (May Committee) commented on the need for an urgent review because of the insufficient number of prison medical officers. For doctors working in prisons and prisoners themselves an improvement in the health care is still contingent on there being an expansion of medical services. For this development to occur there must be changes in the prison doctor's role so that adequate numbers of suitably qualified and competent practitioners can be recruited.

The cost of printing and publishing these Minutes of Evidence is estimated by Her Majesty's Stationery Office at £3240.

1.2 The Need for a Training Grade

The Prison Medical Service must be able to compete with the NHS and the Armed Forces in offering encouragement to begin or continue training in one of the medical specialities. As elsewhere training grades educational needs would have priority over service demands.

Experience in prisons should be recognised as part of both general professional and specialist training. Doctors working in prisons should be encouraged to continue their medical education and get further experience outside so that they can obtain qualifications which would be of use to them whether or not they wish to make a career of prison medicine.

For relatively inexperienced doctors, working in the Prison Medical Service would be much more attractive if, on moving from the NHS, training could be continued and the Service were not seen as a dead end, only of use to those who had no other career ambitions.

1.3 Part-time Appointments in the NHS

To counter the isolation of prison work it is necessary for both prison doctors in training and established medical staff to have part-time or honorary appointments in the NHS.

A much larger medical establishment is required if services to prisoners are to be improved and at the same time doctors are to spend the requisite amount of time in training and in medical practice outside prisons.

1.4 Joint Consultant Appointments with the NHS

These posts have not developed as expected. Apart from one, all such post holders have altered their contracts and are now working predominantly with NHS forensic psychiatry services, continuing to work in prison only on a limited sessional basis. This has occurred because of the difficulties experienced in holding such posts and the expansion of forensic psychiatry services in the NHS in the last 10 years. Other NHS consultant forensic psychiatrists have taken over the freed sessions either as part of their contract or as additional ones. All new consultant forensic psychiatrist posts should have some sessional commitment to prisons in the interest both of prisons and the NHS and the liaison between them.

1.5 The Need for Research

An increase in medical staffing is also necessary if doctors employed to work in prisons are to make a significant contribution to research in prison medicine. The present method of collecting statistics on mentally disordered prisoners is both unrealiable and invalid and the figures are of little scientific use.

For reputable researchers from outside research proposals which are welcomed by prison staff are met by interminable prevarication at central Home Office level so few projects are ever begun.

2. The Doctor's Role in Management

2.1 The 1982 Home Office Report on the Work of the Prison Department emphasised that the prison medical officer, in keeping uppermost his professional responsibility for inmates, acted, on occasions, as an independent referee of the penal system. It seems wholly inappropriate for a medical practitioner to serve this function which is rightly the responsibility of others.

Whether or not medical practitioners should have a role in the management of penal institutions is of course debatable. Their roles in prison disciplinary procedures and the

public health aspects of prisons is an historic one and needs to be reviewed in the light o contemporary medical practice. However, if the doctor is to have a role in management it i important that it is not merely a token one. To contribute effectively to the running o prisons, medical practitioners need to be well organised and well informed and what the have to offer needs to be based entirely on their standing as doctors.

3. Consent

3.1 Treating prisoners for psychological disorder who are unable to consent to treatmen or refuse to do so is based on the common law principal of necessity—life is endangered serious harm to the inmate or others is likely, or there would be an irreversible deterioration in his condition. Other guidelines have been recommended by the Home Office but the are wholly inadequate given the emphasis which is placed on these matters in NHS psychiatry. The whole area of consent in the psychological treatment of prisoners needs t be reviewed urgently both for prison doctors who are often reluctant to treat because o uncertainty regarding their position and for the protection of inmates.

4. The Need for an Improved Working Environment

4.1 The May Committee's comments on the need for an improvement in the physica conditions in which prison medicine is practiced are endorsed. Doctors, like inmates, have been affected by overcrowding and the physical environment in which they work and the resources available to them are downgraded year by year. Working in an impoverished atmosphere is demoralising and unpleasant and special measures are necessary to ensure that the rigours of imprisonment are not shared by the staff.

5. Special Units in the Prisons

5.1 It is inescapable that there wll always be a number of mentally abnormal individuals in prison and it is probable that only a minority of this group should rightly be in hospital

5.2 The argument that opposes the development of psychiatric treatment units in prisons because the NHS would increasingly renege on its responsibility to provide treatment is a persuasive one. There is also a fear that if penal treatment units existed, Courts would sentence people to receive treatment—and prisons could not turn them down—to avoid wrangles with NHS staff who have the discretion whether to accept a patient or not.

5.3 A counter argument is that with the expected closure of large mental hospitals, prisons would be prudent to acknowledge their clientele of abnormal offenders and provide treatment for them. Such treatment units would represent a recognition of the grey area of responsibility between the DHSS and the Home Office; they could be designated as hospitals within the terms of the National Health Service Acts and come under the purview of the DHSS. As designated hospitals, they would be subject to the minstrations of the Mental Health Act Commission and be subject to Consent to Treatment legislation.

5.4 It is noticeable that special environments are being developed within the penal system for mentally disordered offenders. Whether such units have a treatment or control function is uncertain and this should be made quite explicit, but there can only be a medical contribution to them if it is the former.

6. NHS Psychiatry and the Prisons

6.1 Despite recent developments in forensic psychiatry it has always been envisaged that the great majority of mentally abnormal offenders will continue to be treated in conventional psychiatric hospitals and units by general psychiatrist. The regional forensic services, with their secure units, have had a limited and patchy impact on the number of mentally disordered offenders in prison although there is a belief that attitudes to psychiatry have softened somewhat and it is a little easier to obtain treatment facilities.

6.2 Whatever benefit has accrued to mentally abnormal offenders in recent years, is being threatened by restrictions on revenue funding for forensic services by some regions. In being forced to compete again with other health care needs, mentally abnormal offenders are likely to regain their position at the bottom of the table of priorities.

7. Administration and Management

7.1 The provision of health services to prisoners is best provided by single medical organisation.

7.2 In its evidence to the May Committee, the College recommended unequivocally that medical services to prisoners should be provided wholly by the NHS. Experience with forensic psychiatry developments in the NHS suggests that complete amalgamation is no longer a desirable goal.

7.3 Whether the Prison Medical Service should be under the aegis of the Home Office as at present, or part of the DHSS, or managed by a Joint Board of DHSS/Home Office is open to debate. As sole manager, the Home Office suffer the handicap that the Prison Board's remit is to manage a system of punishment within which health care must be provided with all the restrictions this imposes.

No political party will find advantage in extending health resources to prisoners.

7.4 If it were possible for the Prison Medical Service to be managed by the DHSS, as a special health authority, there is no guarantee that it would be better funded. However, if employed by the DHSS, prison doctors might need to depend less on their personal qualities to avoid the conflict of loyalties which their present employer and role engender.

7.5 The forces which work towards preserving the integrity of prisons as institutions are powerful and persuasive ones. Can we really expect that a prison medical officer who is sometimes professionally isolated and often on the defensive because of the nature of his work, can be the standard bearer of the rights of his prisoner patients? Only medical practitioners of the highest calibre could serve such a role and it might be felt that the Home Office was not the most appropriate employer of doctors who work in prisons.

Examination of Witnesses

Dr T H Bewley, President, Dr P Bowden, Chairman, Forensic Psychiatry Specialist Section and Dr H Rollin, Consultant Forensic Psychiatrist to the Home Office, Royal College of Psychiatrists, called in and examined.

Chairman

217. Good afternoon, gentlemen. Thank you for coming to give evidence to us and thank you for the document you have sent us. May I start off by putting to you a point that arose in 1979 when you gave evidence to the May Committee. You did recommend that medical services to prisoners should be provided wholly by the National Health Service, and you say in your memorandum that complete amalgamation of the prison medical service with the NHS is no longer a desirable goal. Obviously you have had a change of mind since 1979, would you like to tell us why?

*(*Dr *Bewley.)* If I could start and then I will ask Dr Bowden to add to it. Going back a rather longer period than that, about 20 years ago, there was a general move towards an increase in the forensic psychiatry input to the prison service and there was a move towards having joint appointments between the NHS and the Prison Medical Service. There was probably a misconception at that time. We, as psychiatrists, looked too much at the psychiatric input and our skills would be in diagnosing mental illness and advising about treating it, but we did not pay enough attention to some of the other things which should be

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done by the prison medical officers, such as the general practice side of their work or the community health side of their work. I think there has been a change. Now we would see a rather more limited role for psychiatrists than we would have at that time. There has been some change of mind. Perhaps I could ask Dr Bowden?

*(*Dr *Bowden.)* I think there was the hope in the College that the DHSS would continue to provide positive discrimination in favour of mentally abnormal offenders. The Butler Committee has given emphasis to that but time has shown that not to be the case, and the National Health Service seems to be reneging on its commitment to provide money and resources for mentally abnormal offenders in the prison service. We felt there was no longer a priority, or we could no longer look to the Health Service to provide for mentally abnormal offenders in the way we hoped they would six years ago. We also believe in the College that patchy attachments to the National Health Service would not provide the extra medical service within the prisons, not necessarily the medical service environment for prison management but one which is involved in the day-to-day health care of the prisoners. Doctors going into the prison in the morning and leaving at lunchtime do not contribute much to the life and the health care of the prisoners and we felt that simple amalgamation was no longer expedient and would no longer improve health care for prisoners in the way we had hoped.

Mr Lewis

218. Am I to assume from that that you do not like to see doctors going in in the morning and finishing at lunchtime?

*(*Dr *Bowden.)* Not at all. The point I was making is that it is important that doctors working in prisons should contribute to the prison environment, the prison milieu. The problem with part-time attachment is that they do not get involved in the broader management of prisons, and they do not contribute to the health care of the prisoners in an atmosphere where only we feel full-time prison medical officers do.

Chairman

219. You do say some of these things are open to debate, but we are endeavouring to get some firm proposals to make to the Secretary of State, the Home Secretary and the DHSS who are involved. What particular solution do you now favour?

*(*Dr *Bewley.)* Perhaps I can take it in sections. The first thing is where colleges have a major input is in standards and education and training, and we had a joint meeting with members of other colleges, physicians, community medicine, fairly recently. One of the things we thought we could do which would be helpful to the prison medical service would be to oversee training and education. We thought that this was something that was not solely the role of any one college. It might be better undertaken under the aegis of the Conference of Presidents. One of the things which we as colleges can do, and the College of Psychiatrists is an important component of this, is to help with the education, and continuing education, of doctors in the prison medical service, and again we have recommended the need for training grades within the prison medical service. This would be one thing we would recommend. Another thing which concerns us very much, and perhaps Dr Rollin could speak to this, is that when the mental hospitals were originally founded, one of their important functions was to treat people who were currently in prison, and some people who were ill in prison were treated in mental hospitals. During the last war Penrose pointed out that in all developed countries there is an inverse relationship between the number of beds in mental hospitals and the number of people in prison. One thing we have seen in the last 20–30 years is an increase in the number of people being discharged from mental hospitals and an increase in the number of mentally disordered offenders who are in prison. I think we have to look hard at this and ask ourselves the question, what is the best place to treat people like this, should we make a greater effort to have them transferred from prison to the National Health Service? We have been failing really in the Health Service and because there are now more people in prison there is the question of providing the same standard of treatment for somebody who is a prisoner as anyone else can have. I think as far as psychiatry is concerned this has certain difficulties insofar as consent to treatment is concerned, consent to medication and so forth.

*(*Dr *Rollin.)* My major preoccupation, Madam Chairman, for many years now has been what I call the individuals who are incurable in psychiatric terms and incorrigible in penal terms. This is an army of chronic schizophrenics who wander around

Chairman *Contd.*]

ınd commit petty offences and who are ;ommitted to mental hospitals, are soon lischarged and so the circular process goes ɔn interminably. It is a sort of revolving loor policy in many ways. At the moment I ım the Home Office consultant at Brixton Prison and it is my lot, *inter alia*, to ecommend that so and so be admitted or e-admitted for the nth time in Hospital X, ınd Hospital X says, "We know Charlie, we ıave known him for years, there is nothing ve can do for him, we will not accept him." Where does this man go? As Dr Bowden aid, I think the NHS is reneging on their luty and obligation under the Mental Health Act in their refusal to admit these ınfortunate people. I think that until there s some re-thinking of the whole policy of ;ommunity care, then this problem of the hronic schizophrenic who wanders, like a ing pong ball, between the prison service nd mental hospital service, will increase.

Mr Galley

220. What should we do with them?

*(*Dr *Rollin.)* I think we have to go back to he concept of providing asylum in the true ense of the term. As a psychiatrist I say this dvisedly, we have over-shot our mark by ttempting to state that we can cure anyhing or everything. This, from my bitter xperience, is far from the truth, and I think ometimes we have to face up to the dire ecessity of going back to the asylum in the est sense of the term.

Mr Winterton

221. To follow up Mr Galley's question, hat are you actually doing about it, ecause the campaign, if you like, or the olicy of community care is gathering ıomentum and more and more asylums re being closed, refuges are being closed, ıe very places which you say are ideal for ıe chronic schizophrenic? What can be one about it? As we are talking probably ıore places are being lost in these very ıstitutions which you indicate from your ɔng experience are ideal for treating and ɔping with and supervising these people.

*(*Dr *Rollin.)* No one has been more ɔciferous than I have in my own profesɔn about what I consider to be a very trospective policy. Community care is a ery talismanic catch-phrase but, beyond at, one has to be careful about considerg its suitability for all people in mental ɔspitals. I feel very strongly indeed that ıtil something is done to reverse this process, particularly in the context of the group of people I am talking about, then the trouble will persist and increase.

Mr Lewis

222. Do I take it that in your reply to Mr Winterton you feel a case can be made out for, in my simple language and judgment, the smaller type of asylum rather than the ones we used to have that held 700–800 or more?

*(*Dr *Rollin.)* I could not agree more, Sir. I think these people need care and attention and I think to think in terms of cure is a nonsense. What they need is care, the most humane care you can devise and to revert in many ways to the early 19th century concept of asylum. "Asylum" has acquired certain overtones by the vast majority of the population—

Mr Winterton

223. A refuge, you mean?

*(*Dr *Rollin.)* Indeed, Sir.

Chairman

224. I must pin you psychiatrists down, because you have not answered the second question I put to you about the various possibilities that you put forward and which one you want to opt for. This is what we are after because we have to make firm recommendations. In your paper you refer to the management of the prison medical service under the Home Office, that is one. The second option you put forward is the prison medical service should be an arm of the Department of Health and Social Security. The third is that there should be a joint force between the Home Office and the DHSS. The fourth is that there should be a special health authority, which has been put forward by other witnesses in their written evidence. Which one do you want to come down on? I want the Royal College's view.

*(*Dr *Bewley.)* I am not sure we should necessarily take an absolutely firm view about matters of management.

225. There is a psychiatrist talking!

*(*Dr *Bewley.)* I will give you a direct opinion later and Dr Rollin will give you a different view! We have to be careful because we are concerned with health and with treatment, and management could go a little wider than that, and there are other things than medical matters in the management of a prison and that is an area where it ceases to be our responsibility. If I were to answer the question of which of the four

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options would be the one we are tending towards at the moment, it would look as if the most sensible suggestion would be the one of a special authority.

226. A special health authority?

*(*Dr *Bewley.)* Yes. Perhaps I could expand on that, because I think the reason for this and some of the difficulty we have had in the past, is that we have not defined clearly enough what the prison medical officer does and what the totality of his role would be, as it obviously spans both specialist expertise and general (in the field of general practice). I think for this reason some hybrid body is probably needed and I think a special authority might be the way to do it.

*(*Dr *Bowden.)* I think the College feels that there are advantages in the Home Office continuing to be the employer, but the disadvantages outweigh those advantages. The particular disadvantage being that the Home Office's headlong flight into what is euphemistically called a justice system, health care within a justice system of punishment, creates problems and a problem of identity for the people working within those systems. I think a joint board is unlikely to work effectively and certainly the Home Office and Department of Health have not shown themselves to manage patients or people who fall between both their stools. The special health authority does seem to be the best alternative. It works adequately for the special hospitals where a smaller health authority within a prison health authority would be, and it really seems to be the best option.

Sir David Price

227. If better provision were made for asylum, along the lines of Dr Rollin's excellent evidence to us, would it be as necessary as you see it now to have a new authority? Might it not be better, particularly taking up your President's point about more involvement in the hygiene and generality of health care and education, to try to improve the existing services? I can draw contrasting parallels from the medical services of the Armed Forces.

*(*Dr *Bowden.)* I do not think there is a shred of empirical evidence that there has been a move from the declining Victorian mausolea for the living to the prisons; there is not a shred of evidence that there has been a move from the declining mental hospitals to the prisons. We have a rapidly increasing prison population and a rapidly declining provision for chronic inadequates in the community, places like common lodging houses, and to see the demise of the asylum and a return to it—which could never happen, I respectfully submit—is to miss the point that perhaps the increase in the chronic inadequate population in the prison has come from the decline in hostels, in large rooming houses in large cities like London. To see a move from prisons for the chronic inadequates to psychiatric asylums seems to be putting psychiatrists as managers in charge of our basically socially inadequate people. Perhaps there would be better ways the society could look to to cope with that problem rather than imprisonment.

228. I am not for a moment disagreeing with you, but you are suggesting we are fighting the problems which are not narrowly medical problems and are having to change from a medical organisation into the more social field. We are quickly getting on to the problem of the socially inadequate in prison, which must surely add to the pressures on people who are already in there because they are socially inadequate.

*(*Dr *Rollin.)* My remarks were made about not the inadequates in our society, although God knows there are all too many of them, but those who are clinically diagnosable as suffering from mental illness. There is an overlap between the two groups, but I am talking about those who are clinically diagnosable as suffering from mental illness, and in all probability these are chronic schizophrenics.

Mr Winterton

229. Am I not right in saying that those who might be reading these minutes in due course will see a complete difference of opinion between yourself—and I happen to agree with you—and Dr Bowden, who obviously does not like the concept of refuge for anybody apparently? You believe that for a chronic schizophrenic, and others perhaps, some of whom can be treated, it is better they should be treated in a refuge or asylum rather than in prison where they should not be in the first place?

*(*Dr *Rollin.)* I am old enough to have started off before this solution of community care was invented, and I remember all too well the old asylums. Admittedly the restrictions there were far too rigorous, but for the people I am trying to delineate, this group of people who I repeat are diagno-

[Mr Winterton *Contd.*]

sably suffering from mental illness, then I cannot see any argument against the provision of accommodation in an asylum or refuge, for humane treatment in very caring conditions. I would much rather see them in a refuge than on the Embankment sleeping in rags or on newspapers.

230. We could talk about this for a long time but can I move on to research and the need for it. All the evidence we have received from branches of the medical profession has referred to the need for more research into the medical needs of the prison population. You imply in your paper that the Home Office is effectively blocking useful research projects by "interminable prevarication". Perhaps it would be appropriate to read the total quotation from your paper: "For reputable researchers from outside research proposals which are welcomed by prison staff are met by interminable prevarication at central Home Office level so few projects are ever begun." Could you expand on that and could you, in hindsight having written it, indicate whether you believe it is fair?

*(*Dr *Bewley.)* I think our view would be that there are more difficulties in endeavouring to mount a research study within the prison service and people with mental illness within prisons than there could be in other places.

*(*Dr *Bowden.)* There was evidence brought to our attention of several research projects that had been put to the Home Office, mainly psychiatrically-based research projects, which had been discussed on the ground in local prisons, had then gone on to the medical directorate at the Home Office and had been warmly received, and then disappeared in the corridors of the Home Office. In discussions with other medical civil servants, the initial encouragement was followed some months later by holding letters and then by silence. This has happened on several occasions to people and organisations that have put forward interesting and valuable projects. The feeling people got was that the Home Office had not any interest in encouraging researchers to do work, not work they would have sponsored necessarily in terms of money but to do work in the prisons.

231. What sort of research work to you think needs to be done about prisoners? Would this be directly improving health care given to prisoners or simply be to the benefit of psychiatry. I am trying to lead you into indicating not only what research you believe needs to be done but further what research projects, which were warmly welcomed by the prison medical directorate, have not seen the light of day and not been proceeded with?

*(*Dr *Bowden.)* One project of which I have knowledge is a project on an issue that we believe at the College is central to improving the health care of prisoners and the role of prison medical officers, and this in the area of consent to treatment. The Mental Health Act does not cover prisoners because prisons are not designated hospitals and there are not adequate consent procedures where consent can be refused. A project was put to the Home Office a long time ago suggesting there should be an inquiry into the issue of consent in prison and that guidelines should be drawn up which would be acceptable to prison staff and bring consent more into line with consent outside prisons in the National Health Service. Although that particular project received initial encouragement, it has since been ignored for many months.

232. Are there any other areas where you think research could be usefully carried out to the benefit of prison health care which you would like to highlight to us now?

*(*Dr *Bowden.)* There are many areas, in particular psychiatry with regard to the relationship between the mental state of prisoners, or mental disorder, and their pattern of offending and their positions in society. Some of that has been done at the Institute but there are many areas worthy of development; the relationship of mental disorder and crime in criminal populations.

233. Do the other two have any views?

*(*Dr *Rollin.)* I hate to appear a dissenting voice from my colleagues but I think it would be wrong to give the impression that all research projects are countermanded by the Home Office. I am sure Dr Bowden would agree, despite all the opposition, real or imaginary, which has gone on that some work has come out from research in prisons.

234. There seems to be all sorts of assent and dissent in this room! Could you highlight areas where you think research could be usefully carried out to the benefit of prisoners' overall health care?

*(*Dr *Rollin.)* I would like to see research into the alternatives, and I come back to my old hobby horse, what are the alternatives to the implementation of the 1983 Mental

[Mr Winterton *Contd.*]

Health Act, which says quite categorically that if a man is mentally ill he should be treated and not punished. At this moment we are denied those facilities because there is opposition from the responsible medical officers in the mental hospitals to accept these people back in their hospitals.

235. Is this not because of the trend towards community care and the closure of the mental hospitals?

*(*Dr *Rollin.)* I am sure that is the final answer.

236. Under "The Need for Research" you say: "The present method of collecting statistics on mentally disordered prisoners is both unreliable and invalid and the figures are of little scientific use." Can you explain why? Have you, as a College, sought to change it, to get it right? This is a pretty outspoken condemnation, can you justify it or can you tell us how you have tried to get it changed? Would you like to make any further comment and explain why you come out with that very forceful comment?

*(*Dr *Bewley.)* I certainly hope we can justify it, and I am sure your Chairman will be delighted we have expressed ourselves clearly about something! Perhaps I can ask Dr Bowden to give chapter and verse.

*(*Dr *Bowden.)* The round robin that went to the senior doctors in the prisons asked the doctors on a certain date to tell the Home Office how many individuals were in the prison who should be in mental hospitals. That was the criterion they were asked to judge. There was no definition of what the characteristics of the individual should be, that was left wholly to the judgment of the senior doctor. The senior doctors in the prisons, not unnaturally, all had different criteria and therefore the method of identifying these individuals was quite unreliable. The method was also invalid because the prison doctors were using totally different criteria to identify who should be in the hospitals rather than prison. Some prisons sent back lists saying "Nobody" and others, equally large, saying "Hundreds". It is very difficult to see how these figures can be used in any way, in any scientific way at all.

237. That does not reflect too favourably upon the doctors within the prisons, that they are unable among themselves as professional people to establish acceptable criteria upon which such a question can be asked?

*(*Dr *Bowden.)* I have no knowledge of the workings of the Civil Service—perhaps they were being asked to exercise initiative. Certainly, if the Home Office had troubled to find the criteria, the selection criteria, if they had defined the selection criteria in a proper way and taken advice about how to define those criteria, they would have had information that was more reliable and more valid and it could have been used perhaps to help us understand how many individuals are in prison who should not be there.

238. Who do you fault, then, for the way that particular statistic was gathered or not gathered, as the case may be? Do you blame the Home Office or do you blame the profession?

*(*Dr *Bowden.)* I do not know that we are here to apportion blame.

239. Oh yes we are! Could you please give your view as to which you think is appropriate. Would you blame the Home Office or would you blame the profession?

*(*Dr *Bewley.)* I would blame both really because what we are talking about is doing a careful research to find out exactly how many people there are, and to a certain extent it is up to us as a profession to say "We would like to do it in such and such a way". On the other hand, from the point of view of management, I think the Home Office has a duty really to find out how many people there are who are mentally ill, who should properly be looked after in hospital. I think we can apportion blame on both sides. But again, this is one of the things on which we said that there was a need for more research. I think simple epidemiological research to discover exactly how many people in prison are mentally ill is still lacking. I think there is a difficulty, as Dr Rollin has said, because of the difficulty of getting some people into hospital. There may be people who give up trying to get somebody into hospital because they know it is going to be very, very difficult or impossible. Then, when they are asked, how many people do you have who should be in hospital, they merely say five, and these are the ones who are going to go to hospital because they are very severely ill. There are many others who might go if there were places for them who do not get counted. Because of this one gets the kind of results that Dr Bowden has mentioned, which are not of much value; where one prison, because of the way that the numbers

[Mr Winterton *Contd.*]

have been selected, says there are a large number of people, and another, very similar prison, say hardly any at all.

*(*Dr *Rollin.)* The answer will depend entirely on the psychiatric sophistication of the doctors asked this question. One cannot assume that everyone who is in the prison medical service is psychiatrically experienced. Therefore, to ask someone who is perhaps a bone surgeon or a paediatrician about how many schizophrenics there are in his care is really a total nonsense. You have to unify the people who are answering the question. Until such time as this comes about, you are bound to get this tremendous discrepancy.

240. There surely should be increased cooperation, discussion and consultation between the profession and the Home Office?

*(*Dr *Rollin.)* That is absolutely true.

Sir David Price

241. I do find it quite astonishing that, knowing how government departments work a little bit, that to send out a survey questionnaire to all prisons without some note of guidance, preferably some note of guidance that presumably the Chief Medical Officer has agreed professionally, I find quite astonishing?

*(*Dr *Rollin.)* This may well be.

Sir David Price: Normally, in the DHSS, no Chief Medical Officer would let that happen without putting his imprint on it.

Rev Smyth

242. I am slightly puzzled here because wherever we have visited, most of the doctors have been psychiatrists?

*(*Dr *Rollin.)* In the prison service?

Rev Smyth: Yes.

Chairman

243. We have not been to many yet. Do not draw too much from that.

*(*Dr *Bewley.)* I think it varies, depending on the size of the prison. The larger remand prisons will have more psychiatrists working there and smaller, local prisons will have more general practitioners. Again, there will be a different ratio in the part-time ones in which case there will be more general practitioners.

Mr Galley

244. If you were setting the criteria, what sort of specific groups would you like to know about and how would you seek to cope with those different groups? I go back to a general comment in your paper, that it is inescapable that there will always be a number of mentally abnormal individuals. That is a very broad term. One would need to deal with different groups within that term "mentally abnormal" in different ways. What groups would you identify and how would you cope with them?

*(*Dr *Bewley.)* There would be different groups. One group which Dr Rollin has mentioned would be people with schizophrenic illnesses. Those people with schizophrenic illnesses, who have what we describe as "negative symptoms"—they are apathetic, anergic, unable to look after themselves, who may drift into prison—are much more likely to be overlooked unless they are seen by a psychiatrist because the person sits quietly by himself in his prison cell just mumbling to himself for the length of time he is there. The whole field of people who have schizophrenia, who end up in prison would be one group. I think another group we should be concerned about are people who have problems with alcohol. Some of these will be people who will be ill; some of them will be people who are not ill but who still have a problem with alcohol. Certainly, another reason for the increased numbers of people in prison in the last 30 years is the decrease in the real price of alcohol. We all drink more, and more people are involved in anti-social activities associated with that. There are more people with severe drinking problems in prison than there would have been 30 or 40 years ago. I could continue and say we would also have people with grossly abnormal personality disorders, sometimes described as psychopaths. Here would be another group of people who have committed serious offences who are in prison. With all of these, one has to ask oneself the question, "Is this somebody who would be more appropriately treated in a hospital facility rather than in prison?"

Mrs Currie

245. And what would your answer be?

*(*Dr *Rollin.)* I think it would depend. I think at the moment there are probably—in fact I know there are—too many people in prison who should be in hospital.

Mr Galley

246. Does the Royal College support the

[Mr Galley *Contd.*]

view put very clearly by Dr Rollin that anyone who is mentally ill, including the schizophrenic, the psychopathic and others, should not be in prison but should be in a hospital of some kind? I do not think I am misinterpreting what you said?

*(*Dr *Rollin.)* Should be receiving treatment. What I said was, those who were suffering from clearly diagnosable mental disorder should be treated and not punished.

247. Right. So that would mean a prison hospital or a special hospital or an NHS unit?

*(*Dr *Rollin.)* Or an asylum.

248. Or an NHS mental hospital. Any of those alternatives would be suitable, including the prison hospital?

*(*Dr *Rollin.)* I see this whole conglomeration of treatment facilities as part and parcel of the whole global system.

249. How does that square with the comment you then make in your paper. "It is probable that only a minority of this group should rightly be in hospital." What does that statement mean?

*(*Dr *Bowden.)* I think it is quite clear there is a chance overlap between the criminally and mentally ill populations. 1 in 4 people are likely to be convicted of an indictable offence at some time in their life, and 1 in 7 has a serious episode of mental illness; so the chance of overlap between the two populations is quite great. Also, perhaps a similar group of people, their conviction will be related in some way to their mental disorder. We are not really certain about the proportion of chance and whether there is a definite relationship. We are not certain about that. People have looked at populations of prisoners and have looked at the prevalence of mental disorder in prisons. There have been many studies looked in varying degrees of sophistication. Some studies have looked at what groups of patients should rightly be in mental hospital and most of the studies that have actually done that have suggested there are very few. There are lots of very disturbed, chronic psychotics in prison—many, many chronic psychotics. Many people in *delirium tremens*, who withdraw from alcohol in prison. It is also quite clear that no contemporary psychiatric facility could manage these types of patients. There are a very small number of secure regional unit beds which are all full and the chance of admitting patients on an urgent basis are very slim. It does seem realistic to accept that there are very many mentally disordered criminals who cannot and could not be managed in contemporary hospital facilities. There are many criminals who have episodes of mental disorder during periods of imprisonment. Whether or not these groups of people should receive care is a different issue. The question is, should they be transferred to the National Health Service. We believe that it would be unrealistic to accept the majority of these individuals should be transferred to the Health Service but that they should receive proper care in prisons.

Mrs Currie

250. That is not what your paper says. You are now saying it is unrealistic that they should go to hospital. Your paper actually talks about whether it is a right they should be in hospital or not. This is what our Committee is all about. Are you not confusing the two?

*(*Dr *Bewley.)* Could I come in on this. I think what we are concerned about is that anyone, whether a prisoner or not, should have the best possible treatment available. I think, in a sense, whether the person has it in prison or elsewhere is perhaps secondary to that. The person, because he is a prisoner, should not be in any way worse treated or get less good treatment than elsewhere. I think that the two further points are that it is at the moment much harder to find an appropriate place in the NHS for the person to have treatment, but he should not fail to have treatment because of that. Maybe he needs treatment for an episode of illness while he is in prison. At the end of the day, as far as we are concerned as a college, we would strongly emphasise that it is getting the necessary treatment that is the important thing. Again we have also adverted to it elsewhere—we are concerned that the person may be both remaining in prison and not getting the best treatment because of problems about consent to treatment and because people are unwilling to give certain treatments within prisons because they may feel, the next thing is, people will complain that "you are putting normal people in a chemical straitjacket". I think there are some quite difficult problems in diagnosing the illnesses, and ensuring that people are treated. I do not think we would feel

[Mrs Currie *Contd.*]

that there would not be this Committee if there was no disquiet about whether or not people are getting what we feel they should be entitled to.

Chairman

251. I think we have to face the fact too that if the Health Service were to be asked to provide the sort of resources that you are talking about for patients, they would have to make additiional provision, which does not exist at the present time within the Health Service hospital. There is that problem, is there not, of security and appropriate people to provide the treatment and the nursing and so on?

*(*Dr *Bewley.)* Yes.

Mr Favell

252. You said earlier that 1 in 7 people suffer from some kind of mental disorder at some time or 1 in 7 receive treatment at some time. Presumably there is a larger number that do suffer from some mental disorder and do not receive treatment? It would be interesting to know what proportion of the population at any time is suffering from some form of mental disorder? Quite clearly, you cannot put them all in hospital so you are bound to get people passing through the prison. You are bound to get them. Is it not as well that treatment should be given there rather than expecting the NHS to deal with them?

*(*Dr *Bewley.)* I think inevitably, both will be needed. There will be some people who go from prison into a hospital, they may be going to a special hospital for treatment but at the end of the day the practicalities are such that some people will have illnesses within the prison and it would be desirable that they would have treatment there. Dr Rollin would like, if it were possible, to see them all going to a hospital, albeit a secure hospital. But when we look at what has happened in the last 30 years, we are very short of secure facilities within the NHS.

253. For how long do you suggest they should be kept in a secure hospital? What proportion of the population would end up in a secure hospital?

*(*Dr *Rollin.)* As a corollary of what I was saying earlier, it is my firm belief that long term treatment of psychiatric patients in prison is not on. I think it is ethically and morally absolutely wrong. I think all the person can be expected to do is provide first aid treatment. For anything which is going to be a long-term project then my conviction, having been an NHS consultant and now working as a Home Office consultant, is that the two are incompatible.

Mr Winterton: How would you reconcile that with, for instance, what might happen in 12 months time when Ian Brady, who has been transferred to a special hospital, but who, because of the rules within Europe can——

Chairman: We do not want to discuss Brady now. Do not answer that, gentlemen.

Mr Winterton

254. I insist! What would happen to him if, under the laws and regulations of the European Community, he can apply to a tribunal to come out of a special hospital, but he would not have had that same privilege if he had been in hospital?

*(*Dr *Bewley.)* I do not think we should discuss individual cases, but my assumption would be, if he was completely recovered, he would go back to prison. I think we could get into difficulties if we talk about individual cases, and I would hate to speculate about someone about whom I know very little.

Mr Galley

255. The corollary would now be that we have a separate category of hospital practices linked with the prisons, and that the courts would have the right to sentence people not to imprisonment but treatment. That seems to be what you are suggesting.

*(*Dr *Rollin.)* This is as the Act stands today.

256. Was there not a suggestion that really an awful lot of people are being sentenced to imprisonment who could be sentenced to treatment in a secure asylum?

*(*Dr *Rollin.)* I am talking about people who have been recommended for admission to a mental hospital under the appropriate section of the 1983 Act but who are refused for one reason or another.

Sir David Price

257. I think this takes us on to the arguments for and against setting up penal treatment units. Can we ask you, with your balanced arguments, which side you come down in favour of?

*(*Dr *Bewley.)* Like everybody else I think the College of Psychiatrists is not a monolithic college with all of us thinking the same things. They always say if you have

[Sir David Price *Contd.*]

three doctors you have four opinions, and I suppose we are like other doctors. At the end of the day, ideally, we would like to see people all being treated in hospital but if that is not going to be possible then it should be the next best place; if people are to receive treatment in prison there are already special units, such as the one at Holloway for women with problems of drug dependence, and one can see these would be of some value.

258. Would you see a need for a development of treatment centres within the prison service for drug abuse? The impression we got, when we did our report on drug abuse earlier this year, was that this is a growing sector of the prison population, and that often the courts felt that this was not the right place to send them but they ended up going to prison because there were not the alternatives?

*(*Dr *Bewley.)* They mostly go to prison because of the offences they have committed, and there will be a large medical input when the person is first arrested because they may be physically dependent on drugs and have withdrawal problems if they are not properly treated, but at the end of the day there is not a treatment that you can give to somebody while they are detained, and somehow they come out a different person and can function better. I think there is a lot of general advice and there may be some degree of counselling which can be done and this can often be done better in groups than singly. These are all partial assistance which can be offered to people, but I suspect there are other reasons for keeping people in similar conditions together; it makes it easier from the management point of view. This is a personal view but I do not think there is a specific treatment one would want to lay on for people who have drug dependence problems in prison.

*(*Dr *Bowden.)* In the 1930s it was considered that psychotherapy could affect recividism and two psychiatrists recommended that people should be sent to prison so the system could help them, and in fact courts used to sentence people to longer sentences and made it clear they were doing so so they would have the benefit of long-term psychotherapy. There was no evidence that psychotherapy did affect recidivism. The great trap, particularly with drug treatment units is that courts will start sending drug addicts to prison to serve sentences covertly, just as they did with alcoholics. We do know that prisons are used as detoxification centres, de-lousing centres and acute psychiatric clinics quite covertly. If we develop special treatment centres in prison, people will be sent to prison to have those facilities, and that seems inescapable. Against that we have to balance the fact that there are mentally disordered individuals who will be serving sentences, remanded for security reasons, considered a bail risk, who need to be treated. My own view is that we must be careful that courts are not allowed to send them there for treatment. We must recognise that we must have proper consent procedures so we can treat them properly, but to ignore them seems foolish.

259. Following up the points you have just made, do you think there is a danger that if you develop treatment units that you encourage the NHS authorities to renege on their responsibilities, and that the problem of not accepting patients under the Mental Health Act will increase that tendency?

*(*Dr *Bewley.)* It will push it in that direction.

260. One can see it from the point of view of the staff, "If we can cream off the more difficult ones on to the prison service, it makes our life easier".

*(*Dr *Rollin.)* I would be firmly against any concept which included sentencing for treatment. I think treatment and prison sentences must be kept absolutely apart.

261. You say that special environments for mentally disordered prisoners are already being developed, but it is unclear whether they are for treatment or for control. Could you clear that up?

*(*Dr *Bowden.)* Could you point out where that is in our paper?

262. Page three, 5.4. Also, following that, are you concerned about the use of rule 43 and prolonged solitary confinement for control?

*(*Dr *Bowden.)* I think this arises from some evidence brought to the College's attention regarding special units at Wakefield and C Wing at Parkhurst, where there were some extremely disruptive individuals who also suffered from mental disorder, possibly as a result of the manner in which they had been incarcerated over a long period of time; they were mentally disordered anyway but they were very dangerous and sometimes very ill. It was brought to our attention with some of those individuals

[Sir David Price *Contd.*]

that it was difficult to distinguish between the control of their mental illness for penal control purposes and the control of their illness for primary health care purposes, and the two things are separate. There was evidence brought to our notice regarding a unit at Wakefield, where it seemed that the function of the unit was in fact penal control, although there was very strong evidence that the primary problems were to do with mental disorder. We felt there was a danger of psychiatry being exploited for the purposes of penal control, which seemed quite inappropriate, but the dividing line between penal control and proper treatment in dangerous individuals must be strictly drawn.

263. Do you see a danger of the use of rule 43 and prolonged solitary confinement for control purposes? Following up your concern here do you have any evidence this happens particularly, through no fault of their own, when the local staff are below strength?

*(*Dr *Bowden.)* In my own experience, the primary reason for rule 43 being used is because of the charges and convictions which the defendants find themselves in prison for, because other prisoners are incited to cause harm to certain prisoners and the prisoners ask to be put on rule 43 to protect themselves from retribution which is incited.

Chairman

264. We were told that at Parkhurst, where we went recently.

*(*Dr *Rollin.)* In the majority of cases, it is the prisoner himself who requests rule 43, because of the fear, real or imaginary, of threats to his own safety.

Mr Favell

265. How do you see the future of Grendon?

*(*Dr *Bowden.)* Grendon's primary purpose is that it is a jewel in the rotting crown of the prison service and it is still the only prison which has acceptable standards of care. Where you have a psychology unit, providing proper standards is a must. There is a great problem in psychiatry, and it is the lack of empirical evidence, that the type of treatment being given will have an effect on people in the long-term; all the more reason why there should be doubts about giving the treatment in prison. Certainly the humane physical environment does not harm the prisoners. So it would seem that Grendon has a great future because it is something of a prison model, not because it is going to turn out rehabilitated, mind-straightened prisoners, but because it is a prison which has defensible standards of care and containment.

266. Grendon is under-staffed at the moment and with the particular specialism they need they feel concerned that they are not able to do what the prison was actually set up to do.

*(*Dr *Bewley.)* Going back to the point that we have made earlier, again it is perhaps the last example of the notion that somehow a psychiatrist and psychiatry will be able to turn some proportion of people from offenders into non-offenders, and I think nowadays we would take the view we are very incapable of doing that and that our real skills are in treating and looking after people with definable mental illness. As Dr Bowden says, it may be an accidental thing, but what is provided at Grendon is more humane than you might have in other prisons, but if we were to go back and say, "Has it proved a successful treatment regime" we would have to answer "No". It is probably a better type of prison for people who are there at the time but it is not one that is providing a model of successful treatment. We are not very successful in changing the behaviour of offenders.

267. I found it desperately sad going there to find not just that psychiatric treatment has no effect, or little effect, but that psychological, decent human treatment has very little effect as well. Is there any information as to why that should be so? Why the re-offending rate is just the same as if they had gone to the worst possible type of prison, or appears to be so?

*(*Dr *Bowden.)* Perhaps, Madam Chairman, the inference is brought to bear on people at Grendon. I think it is important to distinguish between Grendon affecting the man and the reason for his offence. Grendon makes up for the damage that has been done in other prisons. A lot of the work that Grendon does is to make good the damage other prisons do to these personalities, but to expect Grendon to alter people is quite a different thing.

268. Why not? If you have prisoners there who have in some circumstances had all the disadvantages of bad treatment

[Mr Favell *Contd.*]

through childhood, never had a proper roof over their head, never been properly treated by anybody, why should decent treatment not have an effect on them?

*(*Dr *Bewley.)* I think the answer is that some years ago we hoped it would, and that was why Grendon was set up. At the end of the day one notes the research and careful follow-up and it is disappointing. Let me say it is not only in Grendon, but if we look at many of the things we do, the more careful our follow-up the worse we find the results are. It is a fact of medicine that we are not as successful as we would like to be, but that must not stop us from trying. Secondly, Dr Bowden says it may be that we cannot make people better, but it may be that in other ways other prisons may make people worse, in making them more difficult to control.

Mrs Currie

269. Are not those results at Grendon borne out in other parts of the system, for example teenagers in care—it does not matter what you do with them in CHE or secure accommodation, the re-offences are virtually the same. Does that not suggest that criminality is in the culture?

*(*Dr *Bewley.)* I think the days when criminality was an illness and when we were the most appropriate people to treat it was about 20 or 30 years ago, and on the other side of the Atlantic. That is one of the problems that psychiatrists have had, expanding the boundaries of psychiatry unrealistically and the notion that psychiatrists have special skills or knowledge that they can intervene with in some way in all forms of behaviour, and this was far too big a claim which was made. I suppose the height of that was about 30 years ago. Now we can better define what our role should be and what we can do but, again, even if the outcome is not better I think it is important that people are treated as humanely as possible along the way, and for the people we treat unsuccessfuly one feels one would like to put them in the best place until something better comes along and we are rather more effective in our treatment.

Sir David Price

270. You cannot judge the person's environment, you must look at the situation after they leave prison. We can draw a parallel here with de-toxification, it is not the centre where they are de-toxified, it is when they get out and go home and whether within a year they are back into their peer group. Surely a lot of the trouble is that the former inmates of Grendon go back to their old chums?

*(*Dr *Bewley.)* One of the differences between being in prison and being in hospital is that it is much easier to arrange for follow-up when somebody is treated in hospital, particularly if they are in hospital in the area in which they live. The day a sentence ends, that is the end of it, because as soon as the final day comes round he is discharged and then the responsibilities end.

Mr Favell

271. Is there any great belief that the unpleasant conditions in many of our prisons are in fact part of the punishment, or do you subscribe to the view we ought to have more units like Grendon or the Wormwood Scrubs Annex?

*(*Dr *Bowden.)* I think, with respect, it is up to people like you to decide what is appropriate for punishment. I do not think we should be party to a process of punishment. It is for you to decide, we are here to provide health care and particularly psychiatric health care for prisoners and help improve that, and not to decide what conditions will or will not be like in prisons.

Mrs Currie

272. So you are not behaviourists at all?

*(*Dr *Bewley.)* They are mostly psychologists, of course. Psychiatrists do use behavioural methods of treatment but we have to clearly define the particular kinds of conditions they will respond to and the kinds of behavioural treatment, but we have not got any behavioural methods or treatments that totally change personalities so that a chap who is a criminal of the worst kind then gets into the city and becomes a merchant banker.

Mr Favell

273. We have touched on this earlier, but you have called for an urgent review of the area of consent in the psychological treatment of prisoners. How often does this actually cause problems for doctors in prisons and in what circumstances?

*(*Dr *Bewley.)* I think the circumstances which are difficult are, for example, on the question of giving a psychoactive drug, perhaps by injection, to somebody who is disturbed.

*(*Dr *Bowden.)* Dr Rollin will also have

[Mr Favell *Contd.*]

very important things to say on this. It is something which comes up every day and is an issue with many people in prison. We are talking about acutely psychotic individuals who behave in a dangerous way to themselves or others, and who are suffering greatly because of their abnormal mental experience. At the moment we are giving them treatment without consent on the common law defence of necessity. That is wholly unacceptable outside prisons and now the 1983 Act and the Mental Health Commission have acknowledged that. In prison, day after day, I inveigle, and sometimes give injections of anti-psychotic drugs to individuals who do not consent, something I could not do if I was in the National Health Service and would be sued if I did. I do it repeatedly on the basis of it being an urgent necessity, which is a farce. I do it because it is important for the prisoner to have treatment to reduce their psychotic illness and make them more manageable and less of a danger.

Mr Winterton

274. Outside you would not do it?

*(*Dr *Bowden.)* Outside I could not do it!

275. So they would be a danger to themselves?

*(*Dr *Bewley.)* He would do it but he would be in a different situation, because the person would be under a section of the Mental Health Act and he could have very rapidly a second opinion report from the Commission and then he would be entitled to do it.

*(*Dr *Bowden.)* The other important corollary is that there are large numbers of prisoners who prison officers will not treat, and who psychiatrists are uncertain about treating, because we have no legislative framework to treat them under, other than in a sense foolishness or courage, but there is nothing else. In fact lots of doctors will not treat mental prisoners because they have no framework, other than urgent necessity, on which to treat them. There are long-term prisoners who become psychotic, and I am thinking of one who was transferred to Broadmoor a year ago where the prison authority refused to treat this person with psychosis because he did not consent. We desperately need consent in prison, so we can provide treatment for prisoners who are uncertain and also so that the present system of giving treatment to prisoners who do not agree does not continue.

*(*Dr *Rollin.)* I agree. I support every word Dr Bowden has said. I am acutely aware, in Brixton, of how thin the ice is on which we skate. I want to differentiate clearly between control of the misbehaving prisoner and the man who Dr Bowden is describing, who is a danger to himself and others because of his psychotic experiences. I know a great deal of mud is thrown at the prison medical service because of the use of the "therapeutic cosh", as it is called, but that has to be differentiated clearly from the clearly definable need of giving treatment to people who are a danger to themselves and others.

Mr Lewis

276. Turning to the question of training, how would you like to see the training of general psychiatrists working in the prison system develop?

*(*Dr *Bewley.)* There are two legs to this. I think the general psychiatrists who work in the prison service will have had initial psychiatric training but, compared with their Health Service colleagues, they will probably have less in the way of continuing training, refresher courses and so forth. If one went into the question, if somebody was starting for the first time in the prison service having no psychiatric training, how could he acquire it, then we are getting into new territory. At one time, some 12 years ago, a number of prisons were recognised for training for those who were taking MRC Psych, the examination of the College, but now they would only be recognised for a limited period and as part of overall training for psychiatry. I think if you were going to have psychiatric training there would be no way it could all be provided in the prison service; I think more than that would be required.

*(*Dr *Bowden.)* I think it is quite clear that the unemployment which is chastening other professions has hit medicine, and at the present time the prison medical service is up to complement I believe. The problem is that there is no training grade at the present time; a prison medical officer is appointed but there is no training grade. We believe it should be much easier for young doctors, or middle-aged and old doctors, to go into prison to receive proper training and receive training in other branches, as doctors are encouraged to do in the Armed Forces and other branches of medicine. They then should be able to leave and go back into the NHS or other services and, or develop a career in the prisons. There

[Mr Lewis *Contd.*]

ought to be more flexibility between the prison medical officers and doctors outside. It is very interesting that in prisons things like case conferences, visits to other hospitals, proper libraries, journals, availability of equipment, are all unheard of, but these things occur every day in the National Health Service. Consequently people who want to develop their ideas are discouraged constantly from doing so by the environment in which they work. If we are going to improve the training in prisons, the working environment has to be improved, people have to be encouraged and allowed to sit for all examinations outside. All these things would create a rise in the establishment of prison officers.

277. What work is the Royal College of Psychiatrists doing on this?

*(*Dr *Bewley.)* The answer is not very much. The comparison that Dr Bowden has made with the Army is an interesting one, because we have much more of an input to what goes on in the Army than we would in prisons in the sense that they have training grades and, as Dr Bowden says, they wish people to come back into civilian life at a later stage and people can train as specialists. That being the case, the College has a powerful input, and if we consider their library is not up to standard they will do much to improve it. I think when you have training going on there is a much larger role for colleges in setting standards of training and what is looked at is ultimately the person as a trained specialist.

278. It has been suggested that prison medical officers should be appointed to a particular specialty, for example as psychiatrists. Would your College welcome such a change?

*(*Dr *Bewley.)* We have one branch within our College of forensic psychiatrists who have this extra training; as well as being psychiatrists they have forensic expertise. At one stage the hope was that there would be many more forensic psychiatrists within the prison service than there are at the moment. Our view would be, I think, that however the organisation comes out at the end and we do not want to comment on that too much, the forensic psychiatrists have a very important role to play, because of their extra skills in diagnosis and treatment.

*(*Dr *Bowden.)* I can see the need for a small number of such appointments but in general prisons need people with a wide variety of experience, enormous enthusiasm and courage, a caring evangelistic spirit, rather than people belonging to a particular sector of medicine. It is the individual rather than their specialties in medicine which is important. Most of the dispersal prisons, taking medium-term prisoners, do not need psychiatrists, a few of the prisons do but they are very few; most will not need orthopaedic surgeons, but I think there is a case for a small number of specialist appointments. They should be linked to the NHS. The biggest need is for the all-round doctor, if such animal still exists.

*(*Dr *Bewley.)* Psychiatry is involved in the training of general practitioners, and many general practitioners will spend six months in a psychiatric training post to obtain a certain amount of knowledge which will be useful to them as general practitioners. I would have thought there would be a comparison with prison medical officers who require general practice skills and who would need to know something about and have some forensic psychiatric skills if they were to diagnose some of the more difficult cases that come their way and what is most appropriate in terms of treatment.

Rev Smyth

279. Could we turn to management because we have covered that fairly well. In your submissions you actually say it is debatable whether medical officers should have a role in prison management. Again, is this one of those discussion points you have put forward, or have you come down on a particular side?

*(*Dr *Bewley.)* We have to be careful that our role is fundamentally medicine, as doctors, and so in that sense the total organisation of the prison should not be our concern at all. But, as psychiatrists, if we think that the particular milieu is going to be damaging for somebody and is going to be anti-therapeutic, then we have a role in saying something about that. In general the overall management is something that, as doctors, we should be less involved in.

Chairman

280. Do you think the Mental Health Commission ought to expand to include the prison service?

*(*Dr *Bewley.)* Not immediately because I think they have enough on their plate, and they will get very confused if they take much more on board before they have

[Chairman *Contd.*]

sorted out detained patients. It would be unwise if their remit was extended to everybody, because it would be enormous. I think there would be a case for something, perhaps the Mental Health Commission or some similar body, to take on the role for prisoners that they have for detained patients. At the moment their remit is for detained patients and they are finding they are twice as busy as they expected to be, so if we added informal patients and prisons they would sink under the weight of it. In principle there is a need, but at this stage my recommendation would not be to get the Mental Health Commission into this one.

Chairman: Those are all the questions we have for you. We are most grateful to you for your evidence.

Memorandum submitted by the Royal College of General Practitioners

INTRODUCTION

In this paper it is proposed to consider the following subjects:—

1. The characteristics of the prison population
2. The characteristics of the environment
3. The roles of the Medical Officer
4. The characteristics of other medical staff
5. The nature of the regime governing medical treatment
6. Psychiatric illness and the prison service
7. A summary of current problems in the prison medical service
8. Objectives for change

Information about the prison medical service is difficult to obtain, partly because of secrecy on the part of authorities and partly because of lack of studies. Recent literature includes the series of articles by Richard Smith in the British Medical Journal [1], and two papers—a paper on the health of prisoners in Bedford Prison [2], and a comparison between medical care in prison and general practice [3] also published in the British Medical Journal.

1. CHARACTERISTICS OF THE POPULATION

The population of the prisons in the United Kingdom is young. In the survey carried out in Bedford, 67% of prisoners were younger than 30 and 95% were under 50. This was similar to the figures from Prison Census [4]. The majority of prisoners are from social class 4 and 5. In one survey alcoholism was found to be ten times as common among the prison population as in the community [2]. Inmates have often neglected their health and 46% admitted to Bedford Prison were found to have active medical problems [2]. The prison population is violent, relatively unable to cope with stress, separated from their support systems and prone to suicidal actions. Epilepsy, drug addiction, psychiatric illness are more common in prison than in the community, though the incidence of these problems is lower than that reported in an American prison [5]. The older cohort of prisoners contain a large number of alcoholics who recurrently serve short sentences for drink related offences.

2. CHARACTERISTICS OF THE ENVIRONMENT

By far the greatest problem in prison life is the overcrowded and primitive living conditions. The overcrowding puts a further strain on provisions for education, work and recreation which are already inadequate. The last Health & Safety report for Bedford Prison is attached (Appendix A). The dearth of toilet and bathing facilities are compounded by small numbers of staff able to supervise prisoners while using these facilities. In the older prisons the buildings are old, noisy, dusty, with steep metal staircases between landings. Recently in some prisons the lighting on landings has been reduced as an economy measure. The likelihood of accidents on the steep stairs is considerable. Food in prison is plentiful and often well cooked. It has a very high fat content and low dietary fibre

content. Due to recent cutbacks in staffing the workshops in some establishments have been largely closed down. This has led to prisoners being locked up with three people in a cell designed for one person, for 16 to 19 hours per day.

Smoking in the prisons both among staff and prisoners is ubiquitous. The whole atmosphere of a room is often filled with cigarette smoke posing a hazard even to the non-smokers.

3. Role of the Medical Officer

The medical officer has three main roles:

1. A primary care physician.
2. An industrial medical officer.
3. A penal support role during which he supervises punishments and restraint.

The main constraints on the Medical Officer are:

1. The Official Secrets Act which theoretically makes this report a criminal act. Any information that the authorities want to conceal can be protected under this act [6].
2. Career structures. The full time prison medical officer will think very carefully before he does anything which offends the Home Office. If he causes ripples his career will suffer. The medical officer is thus serving the interests both of the establishment confining and punishing the prisoner, and the prisoner being confined and punished. His career depends on the establishment, not on the prisoner.
3. The prison medical officer, because of these facts, is isolated from debate and audit. Money is often not made available for medical officers to go on courses outside the prison service. This isolation may lead to a slipping of standards and a paranoia about the outside world.
4. The prison medical officer is very exposed to press interest in the welfare of prisoners. He is not always allowed to freely answer criticism and when he does he may not be believed.
5. All these factors lead to poor morale and defensiveness.

4. Characteristics of Other Staff

The hospital is staffed by hospital officers. These men are ordinary prison officers without medical or nursing training. In England and Wales they are given training in basic medical skills for 26 weeks. The training is carried out by instructors from within the prison service, and there is no external assessor involved in the examination at the end of the course. The training in Scotland is for 18 months, and is organised from outside the prison service.

In many other countries, such as the Netherlands, Canada and in the Federal Prison Service of the United States of America, hospital officers are all trained nurses or paramedics.

The hospital officers care for patients ill enough to be admitted to the prison hospital. In many prisons these officers go home at night and there is nobody with any medical training at all on duty in the prison hospitals. Where there is a part time medical officer at an establishment the care of prisoners in hospital is in the hands of staff with a training considerably less than a SEN for most of the day. Recently more SRN trained officers have been recruited into the prison service. These men have full training on recruitment as discipline officers. They have no formal training in counselling and supporting frightened and psychiatrically ill men in the abnormal environment of the prison.

Many prisons have X-ray facilities. These machines are used by hospital officers given two weeks training at one of the medical training establishments. This is potentially extremely dangerous.

Pharmaceutical work in prisons is done by pharmacists or compounders. In many peripheral prisons these work on a low commitment part-time basis.

5. The Medical Regime

Prisoners come in to prison with no notes and no medical information. If they are taking any form of treatment they may well not bring this in with them. Where patients are confused, psychiatrically ill, or withdrawing from drugs or alcohol, making a medical assessment may be even more difficult. Large numbers of prisoners are often presented for examination at the same time. With the consent of a prisoner it is possible to write to a doctor or a hospital for medical information, but there may be a wait before a reply is achieved.

Because of the very high turnover in local prisons, the prisoner may have been moved by the time the information is received. The notes used in the prison medical service (Appendix B)* are extremely badly designed and encourage episodic medicine. The notes from one prison often do not accompany the prisoner when he is moved to another establishment.

If a prisoner feels ill he reports sick at 7.00 am and joins the sick parade. This sick parade is often crowded and rushed. A hospital officer is usually present in the room when the doctor sees the patient. The hospital officer is not perceived by the prisoner as a supportive person. The medical officer has absolute power to treat or not treat the prisoner, or to admit him to hospital. Prisoners often do not understand why a particular course of action is taken. If a medicine is prescribed for the prisoner he has to attend the hospital for each individual dose which is often given to him in a liquid form. If the prisoner has a medical problem after the sick parade has finished, he presents to the hospital. The hospital officer may treat him with simple remedies such as aspirin or simple linctus. The prisoner is totally unable to self medicate and is allowed to take no responsibility for his own health. This increases dependency in a group of men who are already immature, dependent and unable to control their aggressive impulses. If the hospital officer feels that the prisoner is seriously ill he may recall the medical officer.

Admission to hospital is seen as punishment by many prisoners. If a prisoner is thought to be suicidal he is stripped and put in a nylon shirt and shorts in a totally bare room with a mattress on the floor. His glasses, and the right to smoke are taken away from him. He may remain without seeing anybody for the whole day except at meal times. He is effectively in solitary confinement in a strip cell.

Where a prisoner needs treatment or investigation in hospital, there are security problems in most prisons. Some larger prisons have hospitals with operating theatres and properly staffed investigation facilities. In the majority of prisons the prisoner has to attend the local district hospital. He has to be escorted by two prison officers. When there are staff shortages this may lead to delay.

If a prisoner feels that he is being wrongly treated he may appeal to the prison governor or the Board of Visitors. Both of these are perceived as part of the establishment as they are involved in disciplinary action against the prisoner. Prisoners may also appeal to their solicitors or members of Parliament. All letters relating to such appeals have to pass through the prison censors who would refer such matters back to the governor. The prisoner may be persuaded not to continue with his appeal, and the medical officer is advised of the nature of such an appeal.

6. Psychiatrically Ill Prisoners

Many psychiatrically ill people who have committed violent acts are confined in prison. Psychiatrists may be asked into the prison to help in diagnosis and to advise on pharmacological treatment. In some prisons psychiatrists attend regularly. Prison is a very poor environment in which to treat psychiatrically ill men and the non medical personnel in prison hospitals have no training in psychiatry. The prison department were unable to tell me whether any RMN trained nurses are employed in the prison service.

*Nott printed.

Eventually psychiatrically ill prisoners are committed for treatment in hospital. This may take many months. The case of a totally confused violent schizophrenic man who was confined naked and alone in a strip cell in Bedford prison for four and a half months was not unusual. Psychiatrically ill prisoners deteriorate markedly under these conditions.

7. Current Problems

The nature of prison life and the way that the medical services function within this structure has been detailed. The major problems posed by these conditions are:—

1. An abnormal doctor/patient relationship. The doctor is not seen as a trusted adviser, he is seen as the servant of the establishment that is confining the prisoner. This conviction is reinforced by the fact that he is involved in supervising punishments. One consequence of this distrust is that the prisoner is not involved in making a definition of his problem or of a treatment plan. The doctor orders, the patient may grudgingly comply.
2. The notes used in the prison medical service are very badly designed and compound the difficulties of having no past or current histories. Continuing care is almost impossible.
3. A third party, the hospital officer, is present at most consultations. As this person is perceived in an adversorial role by the prisoner the consultation with the doctor is not perceived as confidential.
4. The training of the staff with whom the doctor works is poor. The training for radiology is dangerously inadequate. The cover given to patients in the prison hospital even by these staff is incomplete.
5. The contract of the medical officer makes discussion, dissent and championing his patient's cause deleterious to his career prospects.
6. The whole concept of self help, personal responsibility and patient autonomy is completely lacking in most parts of the prison medical service. A regime where prisoners are given more autonomy exists at Grendon Underwood prison and the Wormwood Scrubs Annexe in England, and Barlinnie Prison Special Unit in Scotland. These experiments are perceived by prison staff as failures as they have not changed the reconviction rate of inmates having served part of their sentences at these institutions. There is some evidence that the regime is beneficial to some of the inmates [7].
7. The care of psychiatrically ill offenders is inappropriate, damaging and cruel.

8. Objectives for Change

1. The overcrowding in prisons must be urgently reduced.
2. The career prospects of prison medical officers must be disassociated from pleasing the establishment of the Prison Service. Employment within the National Health Service would free doctors to care for their patients without endangering their own career prospects.
3. Prison doctors must be urgently disassociated from supervising punishments of prisoners. Nobody can give personal care to inmates in an institution and at the same time supervise that establishment in punishing the inmate.
4. Prison doctors must recognise and treat serious disease and at all times maintain the priority of the needs of the patient over that of the establishment. This would be a reversal of the present instructions as spelled out by Mr C J Train at the 1985 Prison Medical Officer's Conference.
5. Prison Medical staff must aim to maintain the autonomy of the individual patient giving him choices in solving his problems. Some sort of self medication should be encouraged in prison. Until this becomes established the medical service must alleviate minor suffering which would be self medicated in the community.
6. The notes and records in the prison medical service must be urgently upgraded to enable continuity of care and whole person medicine to be practised in the prison service.
7. The prison medical service should be prepared to adopt a counselling and supportive role with the inadequate, the recently sentenced and the depressed. Locking these men in strip cells may remove their ability to take their lives, but it does not help the patient.
8. The prison hospital should provide a secure environment for the violently ill. However the solitary confinement of these men in strip cells for many months is unacceptable. The process for transferring them to hospital should be urgently expedited.
9. The prison doctor should have a major directive role concerning the environment of

the prison including the content of the diet, smoking in the prison, and the level of occupancy which is tolerable.

10. The whole work of the prison medical service should be audited. This should not be hidden behind the Official Secrets Act. The audit shold preferably be done by groups of peers, but it should be seen to be done and the results published. A comparison with medical care in the community would be easier if prison doctors were employed within the National Health Service.

11. The whole morale of the prison medical service needs to change from defensive paranoia to aggressive investigation, standard setting, and openness to outside scrutiny.

APPENDIX A

Health and Safety Report (HMP Bedford)

Introduction

It must be said at the beginning of this report that there is no way that life in a building more than 100 years old which contains more than double the number of inmates it was designed for can be in any way healthy or safe. The overriding health problem is overcrowding. The first priority is to reduce the prison population in Bedford to 50% of its present level.

Sanitary arrangements

I reiterate in this report what I have written before. The fact that 43 closely confined men have to share one toilet in 1985 is appalling. We are glad to hear of plans to reduce this to 21 men sharing a toilet which would reduce the urgency of this problem to merely being unacceptable. We recommend expediting these plans. Since officers have had specific responsibilities for certain landings there has been a marked improvement in the cleanliness of the recesses. However the following problems were noted—

A2, C4 and C3 recesses have cracked and missing tiles.

B4 recess has a rough untiled gulley in the wall.

The unboxed pipes surrounded by dust and rubble in the F2 and F3 recesses are exactly as reported previously. The only change apparent was that the wooden surrounds appear to have gone rotten.

The exercise yard toilets were filthy—if anything worse than when I last reported.

The toilet in the reception area still has no ventilation causing an insanitary nuisance to other prisoners in the waiting room.

Lighting

I continue to be concerned that alternate bulbs have been removed from landing light fittings. If one of the remaining bulbs fails this means that a large part of a landing is in darkness. There is good evidence that a decrease in lighting causes an increase in accidents. In a grossly overcrowded building where many people are using steep metal staircases in dimly lit conditions a serious accident is to be expected sooner rather than later.

Hospital

There has still been no action taken about moving the dental surgery to alternative accommodation. Various plans have been discussed but not come to fruition. Thus the hospital continues to have extremely bad staff facilities. Despite having to deal with dirty infections, violently ill patients, staff have no changing or locker room and no staff shower. The association room for the inmates is totally inadequate.

There is no drain outside the strip cell, into which dirty water can be washed when cleaning out this cell when it has been fouled. In consequence the foul water contaminates the main hospital corridor. The cell itself has chipped flaking paint making efficient cleaning of the walls impossible.

EDUCATION DEPARTMENT

There is no ventilation of the education department staff room and office.

KITCHEN

Many of the floor tiles are cracked and partly missing. The floor is still very slippery posing a very considerable risk to inmates and staff walking between kettles of boiling water. I understand that non slip flooring is being investigated, I welcome this move and would urge that this be expedited.

The diet is well cooked, tasty, there is a good choice and it is professionally prepared. The fat content of the food is still far too high and the dietary fibre content far too low. Change on this point is needed urgently but can probably only be implemented centrally.

WORKSHOPS

The workshops are almost completely closed indefinitely. This is a disaster for morale and for the mental health of the inmates. If prisoners remain locked in their cells for most of each day through the heat of the summer a large increase in serious violence can be expected.

GYMNASIUM

The gymnasium floor is ridged and breaking up making accidents very much more likely. The wooden protection to the pipes at the end of the gym is broken leaving jagged wooden edges. On several occasions when ricocheting balls have hit the fluorescent light fittings the bulbs have shattered showering inmates with glass. This could lead to serious cuts or if the glass entered the eye, blindness.

BATHHOUSE

In one corner there was mould between the tiles and the tiles themselves were dirty.

The fact that prisoners are only allowed one bath per week I suppose dates back to the time when people were sewn into their underclothes for the winter. It is dirty, unhealthy and unacceptable. Prisoners should have at least one bath every other day.

TEA ROOM

The carpet at the entrance was worn through. Somebody could catch their foot in this and break a leg.

OFFICERS MESS

There had been a considerable improvement in safety with the reflooring of the entrance hall and kitchen area. However in the restaurant area the linoleum was worn and in one place was cracked and standing proud. This could cause officers to trip and injure themselves. The bannister of the stairs leading to the first floor was very wobbly and a support was missing.

SMOKING

I continue to be seriously worried by the very high level of smoking among both staff and inmates. Smoking is known to be the single commonest cause of crippling illness and death in this country. Apart from the inhuman overcrowding of the prison, the very high level of smoking is the most important health hazard in the prison. It presents a serious hazard to non smokers as well as smokers since passive smoking has clearly been shown to effect the long term health of those non smokers who live or work near smokers.

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Examination of Witnesses

DR E MARTIN, Part-time Medical Officer and Managing Medical Officer, HM Prison, Bedford and DR D JOLLIFFE, Part-time Medical Officer HM Prison, Saughton, Edinburgh, Royal College of General Practitioners, called in and examined.

Chairman

281. Can I thank you for letting us have your document and for agreeing to help us with the inquiry. Can I ask first of all if you would like to see all the primary health care of prisoners carried out by doctors trained as general practitioners rather than by a mixture of general practitioners and psychiatrists, as is the present situation?

*(*Dr *Martin.)* I would like to see the primary care of prisoners in the hands of people trained in primary care who, when they detect problems they cannot deal with, which need specialist care, hand them on to specialists. I would like the first contact to be a trained primary care physician.

282. No dissent from you, Dr Jolliffe?

*(*Dr *Jolliffe.)* No.

283. What training do general practitioners receive before they become prison medical officers? Or are they just thrown in?

*(*Dr *Jolliffe.)* Speaking as someone who has been a part-time prison medical officer for the last two years, it was because I joined a practice which had the contract to look after Edinburgh Prison. It was my normal work and it was what I learned from colleagues.

Mr Winterton

284. Do you think in hindsight, with that two years' experience, that you might have had special training, or have you been able to cope quite adequately, with the patient care being no less and no worse than you would give to your normal patients? Because you had no special experience with prisoners, had you?

*(*Dr *Jolliffe.)* I can only speak from my own experience, and I would say it is a question of attitude and one's approach; it is the individual. I feel that my care, in terms of primary health care, would have been no different from that which I give to my own patients within the surgery, albeit within the limitations which exist within the prison service. I would say without our particular prison we have excellent liaison with our local psychiatrist, which means on psychiatric problems I can have the advice of a psychiatrist.

Chairman

285. How much of your working week is spent in the prison service?

*(*Dr *Jolliffe.)* With my particular practice four of the doctors go one day a week, so it means I go one or two days a week.

[Mrs Currie *Contd.*]

305. Did you change anything as a result of your audit?

*(*Dr *Martin.)* Yes, we changed several things. We produced a protocol for the admission medicals, we produced a protocol for the discharge medicals, a protocol for fitting people for various works around the prison, we produced our own prison formulary.

306. Can I go to what the implications might be from an audit of this kind, particularly concerned with the full-time prison medical officer, and you say in paragraph 3.2: "The full-time prison medical officer will think very carefully before he does anything which offends the Home Office. If he causes ripples his career will suffer." You are gentlemen of evidence and not of anecdote, what evidence have you got?

*(*Dr *Martin.)* There is very little evidence about the prison medical service. I am quoting what the full-time medical officers have said to me. I am also quoting what I have said to senior medical officers in the prison service when discussing this whole matter with them, and have not been contradicted. It was also in Richard Smith's article, so there are straws in the wind. I have very little evidence but I would challenge people to produce much evidence about care in the prison service.

307. The implication is that being part-time and working mostly for the National Health Service is a major form of protection for the health care of prisoners, would that be right?

*(*Dr *Jolliffe.)* I would believe that to be true.

308. If one were to suggest that the bulk of the care, or even a higher proportion of the care, should be done in the way you do it, how do we preserve some continuity and some overall view of standards? Or do you feel that is happening in terms of relationships with other partners and with your other patients?

*(*Dr *Martin.)* I do not see the problem there. If one is part-time and going in every day to the prison, or the practice is, a group of doctors is giving care to a group of patients. As long as those doctors meet regularly and control their standards, audit their work, I feel that the patients are getting a standard which is controlled, just as much as in general practice. You may say what external controls are there in general practice, the only external control is the professionalism of the general practitioner. There may be other controls of quality of care initiative, which the Royal College of General Practitioners calls for, but the fact of the matter is that these are people getting primary care in the United Kingdom. I would submit they should get primary care the same way as the rest of the population gets primary care, which is through general practitioners. They are not seeing people in hospital, they are the community within a prison wall.

309. Have you ever been told not to make ripples and not to be a nuisance?

*(*Dr *Martin.)* Nobody has told me very many things, and I would ignore them if they did.

Mr Lewis

310. Can we turn to medical records. You say the prison medical notes are extremely badly designed. In what way?

*(*Dr *Martin.)* In this way. (*Appendix B shown to Committee* If somebody comes in today and has a problem, that problem is put down *here* and the notes about what is going on are put down *here* and the treatment *here.* It goes down through each time the patient is seen and then there is another sheet. It would be better if the notes were in an A4 folder as in my practice. When you open it there are running notes on an A4 sheet and a summary card, with the hospital records on the other side. As you open it, you can see the summary of that person's health and you can see the problems. You cannot see what is going on with the present prison notes. This leads to episodic treatment and it should be discouraged forthwith. That is my view.

311. Have you made any efforts to get it changed?

*(*Dr *Martin.)* Yes, I have told the director I think it is terrible.

312. What does he say?

*(*Dr *Martin.)* He says he hopes it will be changed in due course.

Mr Winterton

313. Can we move on to x-rays. On page 3 of your interesting paper you say that x-rays are given by hospital officers with only two weeks specialist training and that this is "potentially extremely dangerous". Would you enlarge on this statement, which is of great interest to us.

*(*Dr *Martin.)* I do not think that the two weeks is enough time to train a radiologist

[Mr Winterton *Contd.*]

in dosage, in protection or in anything, quite honestly. To be quite honest, I would have thought the statement was almost self-evident, that you cannot learn a highly complicated skill in two weeks, and that is certainly the view of the people who have been trained in Bedford.

314. Dangerous to the hospital officer and to the inmate?
*(*Dr *Martin.)* Yes.

Mrs Currie

315. Can you, for comparison, give us the length of training that person would have in hospital?
*(*Dr *Martin.)* Three years.

Mr Favell

316. Do either of you have any experience of women in prison?
*(*Dr *Martin.)* No.

317. You cannot then comment on the statement we have heard, that antenatal care of pregnant women in prison is frequently disrupted and the safety of the women and her child is neglected?
*(*Dr *Martin.)* No.

Mrs Currie

318. Perhaps one of your colleagues might be experienced in a women's prison and might be prepared to write to us on that?
*(*Dr *Martin.)* This was circulated to the members of the college who are prison medical officers and there was no note about women at all. I am not certain we have a member who is in a women's prison. Mr Favell: In that case I will leave it.

Sir David Price

319. You say that in your judgment by far the greatest problem in prison life is over-crowding and primitive living conditions—I think we are all pretty aware of that. Specifically on the effect on prisoners' health, can you see any direct relationship?
*(*Dr *Martin.)* There is American work which shows that as people become more crowded, their coronary and artery diseases go up. I cannot quote you the paper on that, but I do believe that it is quoted in one of my papers I think that I published in the BMJ. But there is documentary evidence.

320. If you will let us have a copy of that?
*(*Dr *Martin.)* Yes, I have several copies.

Rev Smyth

321. I think you call for employment within the NHS for all prison medical officers and at the same time you seek a major directive role concerning the environment of the prison for prisoners. Do you think these two objectives are compatible?
*(*Dr *Jolliffe.)* Yes, I think it can be compatible. It is not that one has become part of the management team but one can point out where the health and safety of prisoners is being compromised by the present conditions that exist within prisons.

322. Is that not already part of the role of doctors in the prison?
*(*Dr *Jolliffe.)* Yes, it is. It is just that it might be easier to fulfil certain of these roles if our employment was taken out with the prison medical service.
*(*Dr *Martin.)* Can I just say if I find that one of my patients is working in a local factory in a way that is going to damage their health, I will make it very clear to the management of that factory and anybody else who is necessary that that must stop in the interests of the patient. That is how general practice works in the community. I do not see any difference in the way that should work in prison. I am not involved in the management of the factory; I do not think I should be involved in the management operations of the prison to do that.

323. I accept the point you are making. I would have thought you were supporting my contention that, even at this moment, the role of the doctor is to make that point very clear. Are you suggesting that, because of the present system, you cannot do it with any great effect?
*(*Dr *Martin.)* I think I am having a moan to say that a lot of things we recommend are not carried out if there are any revenue consequences.

Mr Winterton

324. There is debate on certain things some doctors will put forward because they are not necessarily totally supported by their profession.
*(*Dr *Martin.)* There is debate about everything in medicine, I agree with that.

Rev Smyth

325. This debate carries on. I have known some people who thought at an earlier stage it should be under NHS control who have moved from that view. When you say there may be revenue

[Rev Smyth *Contd.*]

consequences, is it not possible that if the Prison Medical Service became part of the NHS, it would be the last place it would get any money from.

*(*Dr *Martin.)* Not if it was part of general practice because general practitioners—

326. Are they satisfied with all the money coming to them from the Health Service?

*(*Dr *Martin.)* If you are asking me, yes, they are satisfied with the money coming into general practice but do not quote me on that!

327. It is on the record. Your fourth objective for change set out in paragraph 8.4 of your memorandum refers to instructions spelled out by Mr C. J. Train at the 1985 Prison Medical Officers Conference and calls for reversal of these instructions, as I understand it. Could you tell us what you mean by this?

*(*Dr *Martin.)* I think the difference is one of philosophy and I think it is a very important difference. The difference is that in one philosophy or paradigm the doctor is primarily the servant of the confining establishment and involved in carrying out its laws and maintaining its laws; in the other philosophy or paradigm the doctor is primarily responsible to the patient to retain his physical, psychological and social health. The doctor's prime responsibility must be to the patient. He has to work within the limits that are necessary for security but they are not his limits and they are not imposed by him and not managed by him. He accepts that is where he is working and what work he is working with and his concern is the good of the patient. That is very different from having a role in managing the confining establishment.

328. I think we share some of your concerns and views, but when it comes to working them out you have already suggested there may be difficulties. Likewise you advocate a counselling and supportive role for the prison medical staff. Have general practitioners really got the time to play such a role?

*(*Dr *Jolliffe.)* I think general practitioners increasingly do have some counselling roles and they are skills we are rapidly learning within our general practice work. We readily accept that we would not usually have the time to complete that role entirely within the Prison Medical Service. We would like to see more team work with counsellors and psychologists increasingly playing a role, and social workers. So we would not be exclusively the counsellors but we have a role to play within that.

329. Would that vary then from prison to prison, depending on the size, and work out easily in some and not so easily in others?

*(*Dr *Jolliffe.)* That would be correct, yes.

Chairman

330. Would you like to say anything at all about the Directorate of the Prison Medical Service? Do you have any contact with them?

*(*Dr *Martin.)* Yes, with Dr Kilgour and his staff. I think there has been an enormous improvement since Dr Kilgour came along. I found it extremely difficult to work with the previous Director. Dr Kilgour listens to problems and the regional director in our region is again extremely encouraging, although there are problems with the Official Secrets Act etc., etc. They know that I am here and nothing has been put in my way. That is a change, I think.

331. We had Dr Kilgour here, so he could not very well prevent you from coming, could he?

*(*Dr *Martin.)* But he listens. Things really are not moving much—I imagine that is the inertia of the Home Office—but there has been a very definite difference in attitudes since Dr Kilgour has become Director.

332. Do you want to say anything, Dr Jolliffe?

*(*Dr *Jolliffe.)* In Scotland Dr McBlayne has just very recently taken over from Dr Morton. We welcome Dr McBlayne's appointment. He encouraged me to come here today.

Chairman: I think that concludes the questions we want to put to you. Thank you both very much indeed. I once more apologise for keeping you so long.

Memorandum submitted by the Royal College of Nursing of the United Kingdom

The RCN welcomes the opportunity to present evidence to the Social Services Committee in its consideration of the Prison Medical Service as it has for many years taken an interest in the nursing component of health care in prisons.

In its evidence to the Committee on Mentally Abnormal Offenders (Butler), in 1973, the RCN referred to the need for more co-ordination between health care in the prison service and the National Health Service. People in prison, whether on remand or sentenced, have the same right to health care as does any other citizen. The College recognises that health care within the prison service can never offer a full range of services and, therefore, that conventional NHS facilities will continue to be utilised. However, in terms of both philosophy and practice it is considered that it would be preferential for health services within prison/borstal to be an integral part of the National Health Service. The RCN further believes that this could be achieved by converting the present Prison Medical Service into a special health authority.

Nursing practice within the Prison Service should be a reflection of the highest level of care within the National Health Service. Such care should be based on individual care plans organised and planned by qualified nurses. A range of nursing skills will be required for an overall health care policy and the RCN recognises, as reflected in other reports, the need for an increase in the number of qualified psychiatric nurses within the service.

At this point the College would wish to draw attention to the continuing iniquitous situation between the nursing care available to female prisoners and that given to male prisoners. Although it is understood that there has been an increase in qualified nurses within male prisons they still only form a small part of the work force in prison hospitals. Whilst accepting that there is still a small number of prisoners who might be transferred to psychiatric facilities within the NHS, in the College's view there will continue to remain a significant proportion of the prison population who will suffer from some form of mental disorder for which treatment should be available in prison. It is also the RCN's view that appropriately qualified nurses could play a significant part in assisting with overcoming some of the psychological trauma associated with imprisonment. The RCN believes that in order to provide the nursing care appropriate to individuals in prison, nurses should be accountable to other nurses.

It is recognised that any consideration of services within prisons/borstals must take account of the fact that security must have pre-eminence. The College would, however, draw attention to the fact that in the special hospitals and in regional secure units security is also a major factor and, in those circumstances, nurses are equally able, through defined policies, to operate a system which effectively balances security needs with a therapeutic environment. It is not considered that health facilities within the prison service offer any significantly different problems. By giving this responsibility to nurses with proper training, the problem of dependence on uniformed officers in order to give care would be overcome. It is realised that acceptance of this concept might reduce promotion opportunities within the uniformed branch for nurses outwith the health care element of that service.

The problem of providing assistance with basic hygiene especially within the female prison service is one which has concerned College members and has led them to question the professional acceptability, in line with the Code of Conduct of the United Kingdom Central Council for Nurses, Midwives and Health Visitors, of the nursing care which they are allowed to give. The view of the College, even if the prison medical service were to become a special health authority, is that the service will always be a consumer of qualified nurses in that even at basic level in the current circumstances the amount of time student nurses would have to spend outside the prison make the proposition untenable. Such a fact would need to be more specifically taken into account in manpower planning within the health service—an easier proposition if there were to be integration. There would also need to be an identifiable budget for post-basic and continuing nursing education. It is suggested that this activity be controlled by qualified nurse teachers and, again to assist with

integration, the RCN would recommend in the present situation joint appointments with local health authorities.

The third major and crucial area which the RCN is concerned about is the management of nursing services within the prison services. Until 1973 there was a post within the prison service of nursing Matron-in-Chief whose responsibilities were confined almost entirely to the professional nursing staff. There was no comparable post in relation to hospital officers. In 1973 the post of Chief Nursing Officer was created with a view to bringing together the oversight of matters relating to hospital and nursing staff in prisons. That post became vacant in 1978 essentially due to the inability of the postholder to overcome restrictions imposed by the Service which would allow integration and progress. Despite representations by the Royal College of Nursing, a new post has been created which is "to provide advice to the Director of the Prison Medical Service on matters relating to the management of hospital officers and matters of common interest to the hospital and nursing staff." This situation remains anomalous to the College; the establishment of a post to manage an integrated service is still considered to be essential and the grading and salary of such a post must be commensurate with its responsibility. If the prison health service were to be a special health authority this would also afford ease of access to the Chief Nursing Officers of both the post-graduate teaching hospitals and the special hospitals.

In summary, the RCN is of the view that much more could be done by nurses to improve the health care of those committed to prison, but in order to achieve this the contribution of the profession needs to be recognised and requisite practices facilitated. This will require more attention being given to the educational needs of staff and requires a clear management structure which allows nurses to contribute at all levels of policy and decision-making. It is believed that this can best be organised, and the health care of prisoners be more effectively promoted, if the present prison medical service became a special health authority.

Examination of Witnesses

MR P MELLOR, Nurse Adviser to the Society of Psychiatric Nursing, and MR M BROWN, Assistant Nurse Adviser to the Society of Psychiatric Nursing, Royal College of Nursing, called in and examined.

Chairman

333. Good evening. I wonder if you would introduce yourselves?

*(*Mr *Mellor.)* I am Adviser in Psychiatric Nursing to the Royal College of Nursing, but I would not want you to think we are simply here in relation to psychiatry. I have had long contact with nurses in prisons over a number of years. We do have a group within the College, for which my colleague Martin Brown is responsible, for nurses working in a secure environment which includes nurses working in the Prison Medical Service.

334. That would include special hospitals as well?

*(*Mr *Mellor.)* Yes, indeed.

335. Thank you both very much for coming to help the Committee. I apologise to you, as to the previous two witnesses, for keeping you waiting. Can I start off by asking how many members of the Royal College of Nursing are currently working in the Prison Service, if you could separate them as nurses and as hospital officers?

*(*Mr *Mellor.)* We would not have any hospital officers who did not hold a nursing qualification anyway. That would be necessary to be a member of the College. We cannot actually quantify exactly for you because I am afraid the system of our records does not allow that for us. We did actually check our records and could identify six particular establishments within the Prison Service which gave us some 25

[Chairman *Contd.*]

members. So we can simply try to extrapolate that and assume we have probably got about 40 or so members in all within the Prison Nursing Service.

Mr Winterton

336. Mainly Women?

*(*Mr *Mellor.)* In the main, women, but a growing number of men which in a sense reflects the increased recruitment to the Prison Nursing Service over the last few months, most of them, of course, having come from the Health Service, in a sense taking their membership with them across to the Prison Nursing Service.

Chairman

337. We do have some concern about the role of the Director of Nursing Services and his responsibility to advise the Director of the Prison Medical Service on matters relating to the management of hospital officers and matters of common interest to the hospital and nursing staff. Could you tell us why you think there is something wrong with the present management structure and what you would like to do to see it put right, what changes you would like to see?

*(*Mr *Mellor.)* Our concern relates to what we saw, in fact, as being a retrograde step as identified within our evidence in that in 1973 there was an appointment of the Chief Nursing Officer who had responsibility for nursing in both the male and female side of the prison. That situation was rescinded when that person left and the direct responsibility for the present person who heads the nursing service is to the male side only and in a sense his responsibility on that side is mainly advisory.

338. Do you have any experience of the situation in Holloway?

*(*Mr *Mellor.)* I will ask my colleague.

*(*Mr *Brown.)* I have visited on two occasions over the last year and spoken to nurses who work in Holloway.

339. Did they express their worries about their present situation?

*(*Mr *Brown.)* They did indeed. One of the main concerns expressed on both occasions was the inability of nursing staff to have access to prisoners both on remand and sentenced prisoners who had been identified as being appropriate for nursing care. For reasons which I am sure you aware of, prison officers have the right to unlock patients and have the right of access and they decide whether nurses have access. The nurses reported to me on occasion that, having identified a nursing procedure they would wish to carry out, they were unable to do so because the prison officers would not allow them access.

Mr Winterton

340. Following that through, can you give any evidence that the inmates' or prisoners' health had suffered as a result of that?

*(*Mr *Brown.)* I have only my own feelings about the situation. I cannot give you any direct research evidence. I can give you two examples which may help to illuminate the subject. One was a lady who had been sent on remand to Holloway who struck a chord from my own nursing experience, someone who would not be out of place in a mental hospital. She had been for two days in a cell without access to a bath, without access to human companionship in the general sense, she was untidy, unkempt and I had reason to believe she was menstruating. The reason the nursing staff were not allowed access of any sort was because the discipline officers believed she was potentially dangerous. That is one case. The second case was a lady identified to me who had needed a small dressing for a self-inflicted injury on her wrist. She was a lady who was disturbed and becomes disturbed, becomes aggressive, both to herself and to others. The nursing staff were able only to do this dressing through the hatch in the cell door because again the discipline officers would not open the door. In both those cases I would say that the health of the patient had suffered. You cannot in the dressing case follow the guidelines or follow any particular sterile procedure if you are having to deal with somebody through a hatch. In the other case I think the basic requirements of human dignity were certainly not being met in that case.

Chairman

341. It seems the fashion for undue security within the prison is something which is very inequitable to the inmates themselves when they are actually within a secure environment, is it not? You do not need the extra dose of security within the prisons?

*(*Mr *Brown.)* It would seem to us, from our own experiences of the special hospitals and regional secure units where they exist, is that within a controlled perimeter a great deal more freedom is possible.

Mrs Currie

342. May I follow up the reason that your colleagues were given for not being able to treat those patients. The reason they were given was part of the treatment would be dangerous to the nurses. Is there any feeling that that kind of treatment is done as a form of punishment to the prisoner?

*(*Mr *Brown.)* I have no direct evidence, but in discussion with colleagues they feel on occasion this was so. But again they could not definitely identify or prove that is the case.

Mr Winterton

343. What is the solution to that? If you criticise that you must be able to put something forward whereby the matter could be attended to, but without the patient being subject to wounding himself or herself or the prisoner wounding the nurse or any other inmate; what can be done?

*(*Mr *Mellor.)* The problem seems to be that there is this clear distinction between therapeutic activity and security within the prisons. We recognise the difficulty there is in the two running side by side, but now there is sufficient evidence both from the special hospitals and the regional secure units that it is possible to carry out therapeutic activity within a secure environment, not those sort of restrictions, but the division seems to be so clear that in the prison medical service you have security on one side and therapeutic activity on the other and ne'er the twain shall meet.

Sir David Price

344. Do you think in some cases that sort of problem arises because of the shortage of prison staff? Let me take your two cases, they have erred on the side of security because in practice they are under-staffed, quite apart from the fact as well that the establishment is low on staffing ratios?

*(*Mr *Brown.)* That was certainly said to be one of the reasons quoted by the discipline officers, that they were short of staff, but that was not the feeling of the nurses involved, that that was not a reasonable thing to say.

Chairman

345. In your evidence you favour the integration of prison health services into the National Health Service and the conversion of the prison medical service into a special health authority. How would this improve nursing services within the system?

*(*Mr *Mellor.)* We believe first of all it would probably offer a better opportunity to improve the ratio between qualified and unqualified staff within the prison medical service. We also think it would offer a better opportunity for professions within that service to have an external authority to refer to, in terms of overcoming any of the difficulties they currently have. At the present time most of the difficulties have to be dealt with within the prison administration and management of the prison service.

346. There was one point raised with us yesterday at Holloway; we were told that the Home Office does not allow nurses to have trade union representation within the prisons, it has to be done through the POA. What are your views about that? I take it you are concerned?

*(*Mr *Mellor.)* That is a current problem we have and one we are hoping to overcome. It is a problem we had originally and it is becoming overcome.

347. Are you putting pressure on the Home Office?

*(*Mr *Mellor.)* I think it is likely to happen because one of my colleagues had a meeting with RCN colleagues at Holloway and they have elected their own steward to act for them. We recognise immediately there will not be the sort of formal recognition of that steward which would occur within the Health Service, but members have identified that need and have elected somebody. It is something we are pressing for.

Mr Winterton

348. Quiet diplomacy will work.

*(*Mr *Mellor.)* I think it needs to be a little more than quiet!

Chairman

349. I think we met your potential shop steward there yesterday.

*(*Mr *Mellor.)* Probably.

Mr Winterton: Steward, not shop steward!

Mrs Currie

350. Branch secretary, perhaps?

*(*Mr *Mellor.)* Yes.

351. Can I ask you about pay and career structure. Can you tell me how the pay for a nurse working in the prison service would compare, both with a hospital officer, qualified and unqualified, and a nurse working

[Mrs Currie *Contd.*]

in the Health Service perhaps with equivalent prisoners, those in special hospitals or secure units?

*(*Mr *Mellor.)* As I understand the situation, nurses on the female side of the prison use the Whitley Nurses and Midwives Agreement as the basis of their salaries and conditions of work. That is not so with the male side; it is more open.

352. Which ones?

*(*Mr *Mellor.)* The nurses working in the prison services, particularly on the male side, where there is a considerable amount of overtime work, and we recognise this will be one of the difficulties we face in the recommendation we have made for a special health authority. I would not pretend that we have an immediate answer to it, but there is a fairly substantial salary differentiation at the moment between the male side in comparison with special hospitals.

353. So the nurse working in the prison services will earn more than his counterpart on the NHS special hospital. Will he earn more than a hospital officer?

*(*Mr *Mellor.)* The nurses of the hospital are paid the same, so there is no differentiation as far as that is concerned, because in terms of the grading of the post, the prison hospital officer does not hold the nursing qualification that the hospital officer does, and the hospital officer on the male side of the prison will be directing hospital officers to their prison officer, who, as I say, does not hold the qualifications that the hospital officer does.

Chairman

354. I think you have got one or two problems at Holloway, about the lack of increments and salaries over a period of time.

*(*Mr *Mellor.)* We are aware of that, Chairman.

Mrs Currie

355. What about promotion prospects? How often does somebody expect to have to stay at the lowest grade before they move up? Do you get complaints about that?

*(*Mr *Brown.)* Certainly in Holloway, there was concern expressed that there was a considerable delay in promotion for female nursing staff, which was contrary to the impression they had been given in the advertisement and at interview, where promotion and rapid advancement was held out to be one of the attractions of working within the prison service. In the same way that the prison establishment of nursing sisters was constructed, there is a limited number of nursing sister posts. The nursing sister who do work tend to stay for a fairly long period of time. Therefore, any promotion is dependent on retirement or whatever, in that there is a restriction on advancement, and there are more people at the lower level and there is a barrier at the senior level, which means that promotion is not as attractive as they would have understood.

356. Do they move from the prison service into the National Health Service and back again?

*(*Mr *Mellor.)* It is fairly limited, because again, most of the recruits on the male side have come from disciplined officers originally, with very few qualified nurses. It will be interesting to see where that increase in qualified nurses does occur, whether that movement will occur; I suspect that salary differentials will be the problem, but that would be a desirable situation.

357. Could I just ask you for a brief comparison with the medical side; the medical side, or the full-time officers working in the prisons, where a lot of the work is done by GPs coming in? On the nursing side, we have full-time staff working there. Do we have part-timers coming in and is there an equivalent of a district nurse?

*(*Mr *Mellor.)* No, not at all.

358. Would that be a move you would welcome?

*(*Mr *Mellor.)* It is not an issue I have considered in any great detail. I cannot see any immediate advantage of it.

Mr Galley

359. Reference has been made to the difference between hospital staff who are predominantly male, and nursing staff who are predominantly female and the Head of Prison Medical Services had indicated he wants to encourage a structure, based on the idea, it seems to be, of encouraging nurses to become hospital officers, with separate nursing grades gradually fading away "becoming defunct" due to staff wastage, and so to have a new integrated structure. Is that something you would agree with?

*(*Mr *Mellor.)* I would if I believed it would lead to a qualified nursing service, but I do not think, in practice, it is a practicable proposition that that ever would be the case, and I think there is a role for

[Mr Galley *Contd.*]

people who support the nursing staff within the service, but who do not necessarily hold the qualifications. I would be concerned within the present structure that that would still leave the door open for people to move up the hierarchy, but for nurses to be managed by people who do not have the qualifications.

360. Why can we not aim at an "all-qualified system"?

(Mr *Mellor.)* We do not have the qualified nurses to do it.

Chairman

361. We do not have it in hospitals.

(Mr *Mellor.)* No, that is the starting point. In theory it is fine and I would be aiming to see that in our service too, but I do not think it can happen.

Mr Galley

362. So the promotion would depend on qualifications being obtained?

(Mr *Mellor.)* It would depend upon the person concerned having the qualifications and expertise necessary for the job they are going to undertake.

Mr Galley: How much of the job, could you argue, is not really nursing, that a hospital officer does?

Chairman

363. How much of it is administration, for example, and could some of the administration be done by other people and not by the qualified nurses?

(Mr *Brown.)* I think the same problems would arise in deciding the percentage of administration and therapeutic tasks which arise in the present medical service. There are occasions when they will be asked to do administration tasks and also mental therapeutic tasks. I think it is the organisation of how the care is given that is the important thing, not necessarily who does it, but it is how the team is worked to provide the care within the hospital environment, and if nurses are to be used effectively, they should be directed by someone who has a nursing qualification. There will be other tasks, for example, in the NHS, there are Ward Clerks, and there will be people who could fulfill their hospital functions but in the direction of therapeutic activity, then this needs the organisation by those used to controlling and directing qualified staff.

364. What about using the ward clerks to do the clerical tasks?

(Mr *Brown.)* If that is what the people working feel is the need then certainly we would support it.

(Mr *Mellor.)* Could I just add to this question of non-nursing duties by supporting the comments made by the previous witnesses as regards a considerable amount of time being spent by nurses working through the current records machinery to identify the sort of treatment the patient should be having, but in general terms of medication, and this has been raised by a number of our members, and the response is consistently that the matter is being reviewed, but having been being reviewed for a very long time now, it seems some conclusion should now be reached. Our conclusion is, certainly from our members, that the present system is quite difficult in terms of operating a system of care.

Mr Winterton

365. You think there is no reason why the present record system should be changed?

(Mr *Mellor.)* No. I have taken the matter up with Mr Barker myself.

366. So surely it would be cheaper and more effective if the records were the same as in the NHS, where there could be an on-going situation, but at the moment there is no connection between one report on the prison service and one in the National Health Service?

(Mr *Mellor.)* Indeed.

Mr Galley

367. Is there any criteria for staff who are qualified, and if so, is that available to the NHS or Special hospital facilities?

(Mr *Mellor.)* I am not aware that there are any criteria laid down. I think we would say as a minimum level a ratio of qualified to unqualified should be in the proportion of 60:40, which you may recall is in fact the DHSS advice about the ratio of qualified to unqualified staff for psychiatry. We would see that as a minimum ratio from which to start and to improve. I think from the figures which Mr Barker gave to you when he gave evidence, you will see the proportion is nothing like that, in fact it is in the opposite direction.

368. It was about 30 per cent qualified at present.

(Mr *Mellor.)* Yes.

369. What about the management of

[Mr Galley *Contd.*]

prison hospitals, do you think that again could be hived off into separate management functions, or has the management got to be part of the nursing function?

*(*Mr *Mellor.)* We would certainly see nurses playing a major part in terms of the management. It certainly is not solely a nursing function, it would be a multi-disciplinary function within the framework of a special health authority, as we see it.

370. If we have general management in the National Health Service and perhaps we establish a special health authority to look after prisons, should we be looking to employing general management?

*(*Mr *Mellor.)* Providing that the points made by the College to you at the time you were considering Griffiths were taken into account.

Sir David Price

371. Can we move on to training and ask you what qualifications do you, as the Royal College, think appropriate for the nurses recruited to the prison service? SEN? RMN? SRN? Would you like separate qualifications for prison nursing?

*(*Mr *Brown.)* We see the first level qualification, by which I mean registration for SRN or RMN, as being the appropriate qualifications. We believe there should be a mix of both SRNs and RMNs, because both have different skills to contribute. We believe that in order to function effectively within the prison environment there should be a period of further training for registered nurses before they work within the prison service. There is currently a course run by the English National Board on nursing in a secure environment, and we believe that ought to be expanded. It could be that the existing hospital nurse training could be incorporated within some post-basic training for nurses wanting to enter the prison service.

372. Do you think that is comparable with the special training given to nurses in secure units?

*(*Mr *Mellor.)* One of the things which is a concern is that on one side there is, as you probably know, a post-basic course for nurses in that particular area—and indeed the Home Office did use to second some of the prison hospital officers to attend that course—but my understanding is that they have now stopped that, on the basis that they are going to do something on their own. That is a retrograde step, particularly as that allowed an opportunity of mixing with other National Health Service staff and exchanging views, which was very valuable.

373. Do you think there is anything special which has to be taught formally about restraint or do you think the general qualifications would cover that?

*(*Mr *Mellor.)* I think the thing about restraint is that you do not use it unless you absolutely have to. That would be included in the sort of training for nurses who are working in secure environments, where there may be problems of control. Again, on that point, I should say it should only be done in terms of therapeutic activity and not be used as an agent of social control.

Mr Lewis

374. Do you have any involvement in the present 24 week course for hospital officers and would you like to see it changed? If so, how?

*(*Mr *Brown.)* We have no formal involvement at the moment, although I recently attended a hospital officers study day which was for senior hospital officers; the first time a nurse has been asked to do that. I would not want to comment on the 24 week course other than to say it is an improvement on the previous course. There are no specific changes that I would want. I recommend the course as it stands.

Chairman

375. What about the scope for nurses to play a wider role in the field of health education in prisons. Do you think that is a possibility you might press for?

*(*Mr *Mellor.)* That should be an integral part of the role of every nurse in whatever environment they are working. That is possible in prisons. There is a fair deal of evidence about the way in which the environment can affect or produce agressive behaviour or agitated behaviour, and that could be better utilised within the prison generally. Going back to the comments that some of our colleagues have made earlier today, the principal responsibility of the nurse must be with the health care within the Health Service, and at this stage, until we get that sorted out I am afraid I have to say the health education issue would be secondary, but one would hope that could grow as the other problems within the service are sorted out.

376. But there is considerable need in the

[Chairman *Contd.*]

women's prisons where there are a number of small babies. We saw a number yesterday, one only a week old.

*(*Mr *Mellor.)* I think that is becoming more and more evident.

377. But then in the men's prisons as well, they need advice, perhaps on how to avoid having so many babies! Do you think there is a role for health visitors in the prison system?

*(*Mr *Mellor.)* The answer would be the same as with district nurses. I cannot see there is any particular role for a health visitor.

378. Does your colleague have any views on that?

*(*Mr *Brown.)* I would not disagree with that statement, apart from to say that given the nurses were able to assess and direct the care they felt appropriate, it might be valuable for them to call in a colleague who was a health visitor or a district nurse. I think it should be possible, although I would not want to see it as routine visiting. If they felt, for example with young children or babies, that advice was necessary, then I think there should be no restriction on nurses being able to call on their colleagues.

379. I am sure on the whole you think it is better to have permanent staff in the prison to provide these facilities?

*(*Mr *Brown.)* Yes.

Chairman: I think that concludes our questions to you. Thank you very much indeed.

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PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

Wednesday 5 February 1986

Prison Medical Service

Dr John L Kilgour and Mr Peter Barker, BEM

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WEDNESDAY 5 FEBRUARY 1986

Members present

Mrs Renée Short, in the Chair

Mr Roy Galley
Mr Ron Lewis
Sir David Price
Mr Nicholas Winterton

Examination of Witnesses

DR JOHN L KILGOUR, Director of Prison Medical Services, and MR PETER BARKER, BEM, Head of Prison Nursing Services, called in and further examined.

Chairman: Good afternoon. Thank you for coming to see us again.

Sir David Price

380. Can we ask you about the Official Secrets Act? We have been told that prison medical officers are not, for example, allowed to write to the press about their work. Could you explain exactly what restrictions there are on prison medical officers making public statements or—which is the more probable situation—having to respond to media requests for information about the Prison Medical Service and indeed about the prisons in which they work? I think it is the latter that probably raises the question more practically than the former.

*(*Dr *Kilgour.)* I think there are two levels of response to that. The first one is to say that by definition the prison medical officers are civil servants, and so they are under exactly the same restrictions as any other civil servant is. I think that that is really an all-embracing answer. However, perhaps I could amplify it slightly to say that when I joined the Home Office one of the factors that I saw—and, I believe, correctly saw—as one of those which was damaging to morale and public relations, was, I will not say a fear on the part of prison medical officers of speaking to the public, because of the Official Secrets Act, but perhaps a reservation that whenever they were asked for an answer they felt that they had to clear it, and it perhaps may have appeared to them that it took a fair amount of time to get that kind of clearance. What I have tried to do in the last two and a half years is to make it clear to everybody—and by example, if I may say so, too—that they should be prepared to be forthcoming and forthright in disclosing things or in answering questions which quite clearly are of a professional nature and within their competence to answer. Where it becomes something structural, then I tell them that I would expect them to consult me first, or show me a copy of what it was they proposed to do. I may say that in two years and six months roughly now I do not recall forbidding anybody to publish anything that they have sent me, and I suppose there must have been 50 or 60 such applications during that period.

Mr Lewis

381. Would you have any objection to using the term that is frequently used from Whitehall, and that is "A spokesman said this"?

*(*Dr *Kilgour.)* I have tried, as far as I possibly can—and there has not been an exception to this in the last two and a half years in relation to myself—to have a situation whereby anybody who wants to ask me any question gets an answer which they can attribute to me. Of course I talk to my press relations branch broadly and generally, and I talk to my Director-General, the Home Secretary and the Permanent Secretary, on any matters or problems. This may just be good fortune, but there has not really been a controversial issue in that time.

Sir David Price

382. Following up what you were saying, would you normally expect the prison

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[Sir David Price *Contd.*]

medical officer, if there is a question of doubt in his own mind, to refer to you or to your deputy, or to refer to the prison governor?

*(*Dr *Kilgour.)* It would depend on the matter concerned. If it were specifically a matter which involved the prison and that particular establishment, I would expect him to refer to the governor, because again my analogy to my own staff is that irrespective of relative rank, the prison governor is the captain of the ship, and the medical officer, even if he is a very senior chap and perhaps senior to the governor in Civil Service status, is still responsible to the governor in terms of what affects that establishment. The other thing is that when I tell them to refer to me, I make it clear that I am fairly content to be referred to by telephone and they will get an immediate answer.

383. So you would not regard it as advantageous to allow the prison medical officers the same freedom as a normal consultant has within the NHS?

*(*Dr *Kilgour.)* The immediate, straight answer to that question is that it is part of the fact of life of being a civil servant that you are under some constraint in terms of discipline in these functions. However, I have, as I hope I made clear, tried to make this as explicable and as loose an arrangement as we can possibly do, in our own interest.

384. Could we follow that up in respect of prisoners? What would your position be in respect of the mentally abnormal prisoner being interviewed by the media?

*(*Dr *Kilgour.)* You mean being interviewed by the press, or something like that?

385. Yes.

*(*Dr *Kilgour.)* The first thing is that this is partly medical and partly discipline. If he were a patient of the medical officer, then the medical officer would have to be consulted and he would, I believe, not give permission for such a patient to be interviewed, unless the patient himself (1) fully understood what was going to happen, and (2) agreed; because there is no special power.

386. There could be circumstances such as the case of a schizophrenic patient for whom it is doubtful whether valid consent could be given because of his state of health?

*(*Dr *Kilgour.)* Yes. I think that when in doubt a prudent medical officer would be cautious in these circumstances, but this would be for medical professional reasons. He would have an independent status in that, not necessarily referring to me. If he did refer to me, it would be to ask a colleague's advice rather than to ask the boss for permission.

Mr Lewis

387. Have there been any cases that you know of where permission has been refused for a patient to make a public statement to the media?

*(*Dr *Kilgour.)* That goes into matters which are not just of the Prison Medical Service. I do not know of any case where a prison medical officer would have forbidden this to occur, if he had been asked by the governor for his opinion, unless he felt that the individual concerned was not rational and would make a statement which, because of his mental condition, would not be appropriate either for himself or for the service.

Chairman

388. What is the position with regard to the preparation of annual reports on prison medical officers? Whose responsibility is that?

*(*Dr *Kilgour.)* It is interesting. There is a division of responsibility. The report, the initiation of it and its ultimate destination is in the Prison Medical Service. In other words, let us take an example: a prison medical officer working in an establishment would have his report initiated by his senior medical officer, the next in line. All the establishments are to some extent overseen in the field by senior medical officers or by, let us say, peer men. At the stage before it leaves the establishment, we have arranged that there is an insert into each ASR (the annual staff report), which is filled in to comment on the management qualities or otherwise of the medical officer concerned. That is done by the governor. That is inserted into the normal report form. Then the SMO comments on it, then the PMO comments on it, and then I get it. These are stored in my directorate.

389. Was this departure—that the prison governors should have some say in this—discussed with the prison medical officers?

*(*Dr *Kilgour.)* It would have been discussed with my predecessor.

390. How is it brought about?

[Chairman *Contd.*]

*(*Dr *Kilgour.)* I do not think it was done necessarily democratically in the way that you were implying in your question, but I think it would have been decided on their behalf—correctly, in my view—managerially by the Prisons Board and the Personnel Branch, in discussion with the Prison Medical Directorate. There *has* been a very considerable view that the medical report should remain purely medical—in other words, that it would be quite wrong if somebody else were to see it. There has been therefore a suggestion that there should be two reports on each medical officer. In other words, there should be an administrative report commenting on his administrative management capabilities, which would come up via the governor and the regional director and would then end up in my office; and then the medical hierarchy of reporting on his professional competence, which would also come into my office. There would obviously be an area of overlap. It is a logical way to do it, but it would probably be unnecessarily wasteful in terms of time, and it would certainly be more expensive. I think that what we have got as a compromise is not bad. I would think it would be a poor thing if we were to lose the management comments, because they are sometimes very useful indeed.

391. I was just wondering what the attitude of the prison medical officers was to the governors being able to comment on the way in which they carried out their job. Have you had any objection to it by the prison medical officers?

*(*Dr *Kilgour.)* I have had discussions about it, not objections. I have usually—unless I have misunderstood the conversations that I have had—had the feeling that I have persuaded those to whom I was talking that the system that we have was as good a system as we could devise, at least at present. As you know, I spent 19 years in the army. I have also been in other Departments and in the United Nations. Exactly the same problems occurred there. They have come to a similar kind of conclusion: in other words, that one has to have a mixture of professional and managerial competences being commented upon by those who are the most competent to make these judgments. In all these cases they have ended up with a hybrid report very much in the same way as we do. What I am trying to ensure—and, I think, successfully—is that the governor's management remarks are in fact made without his seeing the remarks on medical competence. In other words, the governor makes his report separately, and it is then put into the report by the senior medical officer, then it comes up the medical chain. In that way I think I preserve the medical confidentiality, if you like.

392. So if there are adverse comments about the doctor's work, you then have to exercise the judgment of Solomon!

*(*Dr *Kilgour.)* That is right.

393. You have to mediate in that?

*(*Dr *Kilgour.)* Yes.

394. Have you had to do that very often?

*(*Dr *Kilgour.)* Not that has been in any way anything remotely insoluble as a problem. As I think I indicated in our last discussion, we have had members of the staff who are better than others. To encourage those who are "the others", one needs to know about them of course. Remedial action can then be taken, or at least they can be given the opportunity of improving.

395. What about the work of general practitioners who do part-time work in the prisons? Is their work commented on?

*(*Dr *Kilgour.)* Yes, it is commented on in that way.

396. It is done in the same way?

*(*Dr *Kilgour.)* Yes.

397. What about the consultants who visit the prisons; do they report on this?

*(*Dr *Kilgour.)* There is no formal report on people who are doing sessional work for us.

398. I wonder why not? You should be fair and even-handed, should you not?

*(*Dr *Kilgour.)* Yes, I do know informally. I have the same information on them as I have on my staff.

Chairman: It should be the same for the big boys as for the others.

Mr Lewis

399. Turning to the question of reporting to the courts, the last time you gave evidence, Dr Kilgour, you told us that in a perfect world—which we all admit we have not got, regrettably—psychiatric reports should only be prepared by doctors who had formal psychiatric qualifications, but that this was not always possible. This is what you told us. Is it the policy of the PMS to move towards the situation where only psychiatrists are required to do this work?

*(*Dr *Kilgour.)* As I think we were talking

[Mr Lewis *Contd.*]

about this last time, I say the same thing again: that I regard this as a very important question. One can have an aspiration and the practicability of going as near to that aspiration as one can get. I was told this afternoon, for instance, that in Scotland, while most of the psychiatric reporting is done by sessional psychiatrists from outside, the three full-time medical staff who are working already do in fact do reports to courts, including psychiatric work, and they are not psychiatrists. I do not say that that is the right way to do it, nor to defend what we are doing, but just to indicate that we are not exactly alone in this position. I would like to see it rectified in this way. Again if I could refer to what I said before, in the 32 medical officers I have recruited myself in the last two and a half years, 14 of them have held consultant postgraduate qualifications which would enable them eventually, had they stayed in the community, to have sought a consultant post in due course. So what I hope to do is that using those, and the others who are already in the service with psychiatric postgraduate qualifications, to make sure that these are distributed to cover all the local prisons and the remand centres, which are the main establishments where we require reports to court. But they would not be able to cope with anything like the work. We still have a huge demand and rely on the NHS psychiatric consultants to help us, which they do.

400. One of the things that has emerged on our visits to the prisons to date is that there is a lack of secretarial and administrative back-up for prison medical officers. Are you in a position to do anything about this, or have you done anything about this, or are you likely to do anything about this?

*(*Dr *Kilgour.)* First of all, I am very glad that you have observed that, and it *is* a very widespread feeling of lack among establishments. There has been a very great pressure on manpower over the last few years, and especially the last two or three, when you regard the prison budget as being 89 per cent (at least in medical terms) related to costs of manpower. So it is very difficult to get new people to do jobs. Whenever such a requirement comes up and it is reported to me or my principal medical officers on visits to prison establishments, we back it as strongly as we can. I do know that we have been successful in at least, I would say, a dozen cases in the last couple of years. So it is an uphill struggle, and I would like to see it covered.

401. You have just said that it is difficult in some places to get suitable people to do this job.

*(*Dr *Kilgour.)* I am sorry, not to do the job. I think the difficulty is to get the authority to pay the money to take these people on.

402. Is it the money side, the financial side?

*(*Dr *Kilgour.)* It is the finance and resource side.

403. That is actually holding it down?

*(*Dr *Kilgour.)* Yes indeed.

Mr Winterton

404. On behalf of the Committee, Dr Kilgour, can I thank you very much for the further information paper that you have sent to us about the organisation of the budget of the Prison Medical Service. However, perhaps like a number of my colleagues on the Committee, it is a little difficult, from the extra figures and information that you have given us, to get a breakdown of the costs of the Prison Medical Service and, for example, the cost of drugs that are used within the Prison Medical Service and the cost of the surgical facilities provided. Would you favour, as head of the service, a separate budget for the Prison Medical Service, so that the clear costs and expenditure could be more clearly identified, perhaps not only by people within your own department at the Home Office and within the prisons, but by laymen like ourselves who are interested in the Prison Medical Service?

*(*Dr *Kilgour.)* The answer is yes, flatly and unequivocally. As—I hope—a well-trained manager in several spheres in my life, you cannot manage intelligently unless you have got adequate information. I have to say here immediately that I am well aware of the tremendous efforts which are being made by my colleagues in the Prison Department at the moment, in order to try to modernise—and that means a great deal—the managerial style and structure within the Prison Department as a whole. There is a revolution going on at the moment which is moving from central control to a delegation through regional offices down to establishments, of almost total budgetary allocation, with very little being kept as a reserve. Some people would say that perhaps it is almost trying to go too far too fast, but it is a very courageous move that they are making, and it is calling for a great deal of new training of governors, for

[Mr Winterton *Contd.*]

instance, who are having to take and feel responsibilities which they certainly have not had before. All of this I would like to see reflected in the Prison Medical Service. There are some areas of it where our knowledge of what we are spending is very good. I can help you on any question you want to know, for instance, about the cost of drugs and things like that. For instance—this is just a for instance—the cost of medication required per head two years ago, the figure per head in England and Wales, was 75p per head less than the cost of prescribed medicines in the NHS. When you add to that the fact that we have got a rather more morbid community than the average population is outside, and when you add also to that the fact that the NHS prescriptions do not cover the cost of family remedies—which we have to supply, because everything is supplied in the prison, nothing can be brought in, even aspirin tablets are paid for—you can see that all this comes through our budget. So that the way in which I view it at the moment, what I said to you last session will give you an indication that I am really at the first few steps of changing a fair amount of the management structure and the way we are working, and this is one of the ways of doing it. The first step is that you work out how much your average costs are, then you start comparing establishments with similar establishments, then noticing deviations and investigating them, trying to find reasons for aberrant behaviour in prescribing practices.

405. Have you, within the Prison Medical Service, operated what we have come to know in the last 18 months or so as "the limited list"? Have you operated that, as it were, voluntarily, without any government influence?

*(*Dr *Kilgour.)* The word "voluntarily" is the key word there. Yes, we are doing it. My policy has been to tell the pharmacists and the medical staff that they should follow, in general terms and as closely as possible, what the practice is in the NHS. There is no problem, as you can imagine, with the part-time general practitioners coming in, because they are just doing inside the prison what they do outside. The pharmaceutical hierarchy are encouraging and educating, if you like, the full-time staff on these lines as well, and I do not think we have had any problems about this. I still say, though, that the door should be left open. If a doctor feels that a particular drug *is* required by a particular individual, and can justify it on professional grounds, then I would not forbid it.

406. You do have an element, in some areas, of centralised buying, do you not, of pharmaceutical products?

*(*Dr *Kilgour.)* Yes, we do.

Chairman

407. How can you really make a comparison between the cost of drugs as used in the prisons per head and those used outside?

*(*Dr *Kilgour.)* They are published. They are DHSS statistics and our own statistics. I know my own bill.

408. But you serve a very different clientele, do you not?

*(*Dr *Kilgour.)* Absolutely. That is what I was trying to show: that if you look at the clientele we have, you would expect our bill to be higher. That is why I drew attention to it.

Mr Winterton

409. So really it confounds those pundits who think that everyone in prison is perpetually on medication?

*(*Dr *Kilgour.)* That is right. Or we are in some way making sure that we do not waste the drugs that we buy. There is that element to it. One must be honest. There are an awful lot of drugs lying around in bathrooms and so on.

Mr Winterton: You are very courteous!

Chairman

410. You do not have children, you do not have a lot of very elderly people, do you?

*(*Dr *Kilgour.)* That is right.

Mr Winterton

411. On prison hospitals, could I ask you what are your plans for the future of operating theatres? We have obviously taken a particular interest in theatres and what can go on in hospital within the Prison Service. Is there, for instance, to be a new theatre at Parkhurst Prison? Is the Wormwood Scrubs unit to be reopened? What range of operations do you anticipate will be carried out at the refurbished prison hospital and the theatre at Walton Prison in Liverpool?

*(*Dr *Kilgour.)* The answer to that, if I can take it in the round, is that the general policy is that we should have a surgical facility within the Prison Department; and that if we are going to have that, we should

[Mr Winterton *Contd.*]

have it from the point of view of efficiency in each of the main regional user areas: that is, one in Liverpool, one in London and one on the Isle of Wight (the Isle of Wight one being particularly for high-security). That seems to be a reasonable distribution. We are at the nadir of our surgical fortunes at the moment, because we have had troubles in Liverpool with the building, with the air extraction and with the autoclave in that theatre which has kept it out of action for several months in the last two years. It *will* be coming on stream again this month or next month, and I hope that it will stay on stream. The theatre at Parkhurst was very old-fashioned indeed. When I first saw it—I choose my words—it gave me certain cause for reserve about the way it was being used. The thing that sustained me, though, was the quality of the nursing staff and the proximity of the general hospital just over the road from it. Talking to the surgeons myself, as I did immediately I got there, they were telling me that they could do what they had to do, and that the results were very good. However, we obviously had to improve and update those facilities. That is being done by buying a comparatively expensive but very efficient-looking prefab unit which is going to be put in there. Thereafter the hospital is going to be refurbished completely on a plan which will start the building process following the completion of C Wing at Parkhurst. I think that that will be finally completed at the end of next month, so then Parkhurst will be all right. As to Wormwood Scrubs, we were going to have an interim hospital there, while the new hospital was being built. I have had a personal, very close interest in the new plans for the new hospital. It will be ready, I am told, at the end of this decade—perhaps 1991, I would guess. It is going to be very good, and it will more than supply the needs that we have, I think. It will also supply a training school for nurses and hospital officers.

412. The operations that can be carried out in these hospitals would be the normal run of surgical operations where you do not anticipate any dramatic problems?

*(*Dr *Kilgour.)* Yes. Let me perhaps just say that the reason why we need these establishments at all is that we do have a fair number of high-category prisoners who, like any other human being, do get things going wrong with them. Apart from serious emergencies (when they would probably be taken to an NHS hospital outside to be dealt with), there is a lot of elective surgery, a lot of cold surgery which you can do at a convenient time—things like hernias, varicose veins, bunions, foot problems, orthopaedic work.

413. Appendix?

*(*Dr *Kilgour.)* Yes, it could be, especially a cold appendix, a grumbling appendix, where you decide you would give antibiotics and then take it out in three months' time when the inflammation has settled, that kind of thing. When you have got people who are high category and you put them out into an NHS hospital, the cost of providing an escort, six people for each man, is very high. From a manpower point of view, if—as happens in London—there may be 12 people at any given time, that is 72 discipline staff completely written off. The extra cost, in terms of extra allowances for extra duties and so on, is £2,000 per week per person. So it is really quite a significant factor in costs. Governors get very upset when and if they feel that they are sent too many prisoners who are likely to require such treatment going out. It does occasionally happen; in fact there is a case today where there is an inmate in the South-West of England who has an interesting tropical disease which has to be treated, and it really can only be effectively treated at the Hospital for Tropical Diseases in London. So he has to be brought up here. Part of the difficulty of this particular disease—which is called Loa loa—is that the medicament you have to use does, in a significant number of cases, cause a lot of allergic side reactions, because once it gets at the worm, the tissue breaks down, and they develop reactions to it. This means the patient has got to go to that hospital, and he will be there for three weeks. That is going to cost somebody a lot of money. The governors in London prisons are not exactly fighting over each other to welcome this particular inmate who, nevertheless, has got to come to London. It is an interesting problem.

Mr Lewis

414. So it would be cheaper in the long run, when these units are completed—we saw the one in Liverpool—to bring in surgeons from the NHS to do the operatiion inside the prison?

*(*Dr *Kilgour.)* Yes—and more secure, may I say. Those two elements are both very important

Mr Winterton

415. Could you deal with this quite

[Mr Winterton *Contd.*]

briefly, because you have trespassed into this last question in this series. Could you tell us, Dr Kilgour, something about the respective costs of surgery within the Prison Medical Service and within the National Health Service hospitals?

*(*Dr *Kilgour.)* It is very difficult for me to assess that because, as I say, most of the costs of any large establishment are the personnel involved. However, there are also the overheads of the buildings. I am sure my NHS colleagues could, under their general managers, produce a very accurate figure of what those costs would be. I would find it very difficult to put a figure on those overheads from a prison point of view.

Sir David Price

416. Could we ask you a little about psychotherapy? Are there any plans to extend the type of psychotherapy offered at Grendon or at the Wormwood Scrubs Annex, to other establishments?

*(*Dr *Kilgour.)* There are plans to change the role of Grendon. The plans are to maintain Grendon as a psychiatric prison. I know of no intention to change or modify what is being done at the moment at Wormwood Scrubs at the Annex. In other words, Wormwood Scrubs will continue, even though the building changes may require it to move its location to other points in the establishment. I think it does a lot of very useful work, quite frankly.

417. Therefore, how far do you see it as an extension to other prisons?

*(*Dr *Kilgour.)* The change at Grendon is going to be of a kind which will possibly reduce the number of places by a very modest amount—perhaps one wing's worth —in the next year or two, because what I want to establish in Grendon, as the result of a committee which I chaired and of which Professor John Gunn was a member—of which Dr Malcolm Falk, who has given evidence to you before, is a member also—is that what we would like to do is to change the role of Grendon so that it became more of a facility nationally and was appreciated more by the prison system as a whole as doing a useful job in their eyes. One of the things we would like to do is to set up an acute psychiatric unit which would be of modest size—say, about 20 beds—in Grendon, which would serve the whole system, particularly for those long-term prisoners who have psychotic breakdown but who, with treatment, one would expect to recover and be able to go back into the system and continue the rest of their sentence. That is one of the changes at Grendon. Another of the changes that is in my mind is that when we have recruited sufficient suitable women prison hospital officers, Grendon is a very suitable place to use these women officers in suitable numbers. When we have sufficient numbers —that will be in the next, say, one to two years—that will open the option of having a women's wing in Grendon, which will have a salutary effect on relieving some of the problems that there are at Holloway. The last point I would make here is that I have had some preliminary results on the snap-shot we took in December. This indicates to me that there are perhaps 1,500 mentally disordered inmates in the male system who are serving more than six months, 250 of whom are mentally ill and could usefully be offered some specialised unit treatment. In other words, if one were to earmark 10 or 12 establishments to cover the country, one might be able to put 20 or so into each of these establishments where we could probably insert some mental nurse trained staff who would be able to give more special attention to these people than is at present possible.

Mr Lewis

418. Mr Barker, are you satisfied with what Dr Kilgour has just said about the nursing trained staff, about everything that we have been told within the last 10 minutes; that there will be enough nursing staff to be able to cover the changes that are actually needed, that you foresee?

*(*Mr *Barker.)* I would think that if we intend to increase the number of nursing staff with qualifications, then we would not have them within the service. We might have to regroup direct entrants, as we have already done to fill some of these posts. The acute psychiatric unit that is envisaged at Grendon would seem an ideal place to have qualified nurses working, especially nurses who have a psychiatric qualification.

Sir David Price

419. There is one fairly technical question which does arise from what you say. If you establish an acute unit for psychotics in the prison system, how will you deal with the problem of consent and validity of consent?

*(*Dr *Kilgour.)* I think we still will be under the same constraints as we have at the moment. One should not lose sight of the fact that the majority of cases who require treatment do in fact consent to it. The only

[Sir David Price *Contd.*]

ones that cause the problems are a very small number, but they are a very important group. If people who required treatment had a psychotic breakdown and were not likely to accept it, then these would have to be transferred to an appropriate NHS unit.

420. Within that there is the question is it valid consent, under a prison system?
*(*Dr *Kilgour.)* It is possible to argue—as I was told when I first came into this job—that there can never be full, informed consent by any inmate in the prison system, because you could always argue that there *might* be some element of coercion. Of course, if one followed those lines, we would be able to do nothing.

421. Reverting to your snapshot, how helpful have been the Prison Department's own figures—not yours, but the ones, for instance, which we found in the recent report (Command 9699) and the tables in that? How accurate do you think those figures are, in terms of the sort of patients we are talking about?
*(*Dr *Kilgour.)* I think they *are* accurate, in so far as the system can allow them to be accurate. I think they are not bad. My worry always is that one can always think of a better question to ask when one is collecting data.

422. But your snapshot results are improving on it, are they?
*(*Dr *Kilgour.)* I think so. I was saying, in a rather smug way, earlier on today, that my guestimates have not been far out.

423. We have heard and received a good deal of criticism of the attitude of the Home Office towards proposals for research into the medical needs or, if you like, the medical characteristics of the prison population. How far do you think that is valid? Indeed, what research do *you* personally think needs doing that is not being done?
*(*Dr *Kilgour.)* One of the things that surprised me—and I think I said this before, but perhaps not so explicitly—was the lack of firm data which was available in an epidemiological field. This snapshot is the first remedial step in that direction. The second step which I hope to be undertaking with Professor Gunn in the near future is going to be a more elegant exercise which will show us something which will be really irrefutable. What I am going for at the moment are very rough figures which will at least give me a management "steer" to show that what I am trying to do will be somewhere near what we want.

424. Can I take it, then, from the end of that reply, that you would actually like to see, and welcome, closer links between the Prison Medical Service and university research institutes?
*(*Dr *Kilgour.)* Yes, unequivocally.

425. How is that developing?
*(*Dr *Kilgour.)* I think that we are already on the way to doing that. I am happy to see that my administrative colleagues responsible for the operational service are in fact taking the lead in this. There is a group called the Research Advisory Group, which was set up following the Langdon Committee's report on the control review, which has brought in three well-known academics in this field, including Professor Gunn again, which is making good headway. For instance, there is going to be a conference at Cropwood this April, at Cambridge, which is going to take a wide look at the need for academic co-operation and research in the prison system. I welcome that.

426. We can take it, then, from your reply earlier—we asked you whether you would like your own budget—that you would like within your budget a bit of a research budget?
*(*Dr *Kilgour.)* Yes.

Mr Lewis

427. On the question of medical records, I think you will agree that there is something obviously wrong with the way in which the medical records of prisoners are kept at the moment. Could you tell us how you are planning to improve this? For instance, have you any plans for computerisation? If so, what about the whole question of confidentiality which is very, very important?
*(*Dr *Kilgour.)* There are three large questions in that, and they are all very important. First of all, I have been very unhappy with the medical documentation system in the Prison Department. That was one of the first points on which I expressed a view when I took over the job. The second point that worried me was about confidentiality. The third point that worried me was about computerisation. So you put your finger on a very raw nerve. Where we are, two and a half years later, is that because of various difficulties which were not of the Prison Department's making, the department which was responsible for helping the

[Mr Lewis *Contd.*]

Medical Directorate to review medical documentation—or rather it was the other way around, *they* were in the lead—found it one of the too difficult tasks. So that this year, from about five weeks ago, I have the responsibility in the Medical Directorate for taking the lead in the review of medical documentation. It is due to be commenced during this current year, and the first preliminary steps have already been taken. I do not think it is going to happen very quickly; it is quite a long job. What I would like to do is to go straight to pick out an existing system of documentation which already works. That could be either just taking things from the NHS in the way of slightly amended forms, but the same shape and size, which would be a very familiar way, or perhaps going to the Armed Services and looking at the relatively simple system of documentation that they have, which is a basic big sheet which says what the person looks like, how tall he is, how heavy he is, what his distinguishing marks are, any previous illnesses and things like that, and the fact that he has only got one leg, or something of that order. Then there is a system of documents which are the outpatient record, the inpatient record and a medical envelope in which all these things are kept. In order to do that, you have to have a central documentation store; in other words, for each one you write, you have to make two flimsies to make sure that you do not lose things. Therefore, it is not a very straightforward move, and it is moderately expensive to do. That is one of the reasons that has held things up so far. But whatever happens, during this present administrative year we are going to have made firm progress in this, because it is vitally important that we do. It is also important from the point of view of the record linkage, so that we can pick out previous records of illnesses of people who have been in the system before. There remains, and that leaves, the problem of getting records from the NHS. This is not a criticism of the NHS, but it is very difficult, from inside the prison, as far as I can see in my present investigations, to get more than about 20 per cent of these records easily

Chairman

428. Why is it difficult? Are you saying that the consultants outside do not co-operate?

*(*Dr *Kilgour.)* It is general practitioners' records generally that are the ones. When the average inmate comes in, a lot of them, I regret to say, do not have a doctor when they are outside. Some of them who have a doctor do not want him to know that they are in prison, so they will not tell him or they will not say who the doctor is. Or they give a false name, and when we try to trace the records they are not found. Then finally, with a small number, we ask for them and we do not get a reply, or we do not get a reply in time, and it comes too late to use. So there really are difficulties in the system.

429. What happens when someone is discharged? Do you send the information to the general practitioner—when you know him?

*(*Dr *Kilgour.)* There is the same problem there. The instructions and the guidance given are that anybody who is on treatment at the time of discharge first of all gets a week's treatment of the pills or whatever it is he is on at the time. Then he gets a note which is either written to the doctor if the doctor is known, or he is given a "To whom it may concern", with a medical confidential stamp on it. I am profoundly aware of the fact that this is a scheme of things which works far less often than the times that it does not.

430. If a prisoner is transferred, would you send his prison medical file to the NHS consultant who would be looking after him?

*(*Dr *Kilgour.)* If a prisoner is transferred to a hospital, you mean, outside?

431. Yes.

*(*Dr *Kilgour.)* He would go with a hospital case paper or a note which would summarise and would be an extract of what had gone on. I would expect that to happen.

432. What you are saying is that it is not easy to be certain this his GP is informed when he leaves?

*(*Dr *Kilgour.)* That is exactly so, and particularly with (if I may use that phrase) the "skid row" group in London and some of the other larger cities. You may know of some others who have given evidence to you, I think, from outside. I have been in touch with some of these, trying to make links with them, and with a regrettable lack of success.

433. Could I raise one other matter on the records? It has been put to us that the forms are not necessarily designed for women prisoners; they are all right for men, but women do have differences between themselves.

*(*Dr *Kilgour.)* Indeed, that is true. Some

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of the language on some of the forms has a certain 18th Century ring to it, and they really do need to be brought up to date.

434. Why do you not have special forms for women prisoners?

*(*Dr *Kilgour.)* This will all be done, I trust, with the review, but there is no reason why that particular item should not be done now.

435. I am surprised it was not done before, it is so obvious.

*(*Dr *Kilgour.)* Indeed, but it may surprise you to hear that I have not had this particular complaint brought to my attention.

Mr Lewis

436. Would I be correct to assume that finance is not holding up progress in this field?

*(*Dr *Kilgour.)* There will be a price attached to it. It is so essential that this is done that I cannot believe that that will be a factor in not allowing it to happen. The fact that it has been put onto my directorate's task list for this year means that one has to face the resource consequences.

Mr Winterton

437. Before I move on to the sensitive but important matter of infectious diseases (which I am sure Mr Barker will also want to make some comment about), can I just slip in a very quick question? I think it was noticeable, when we last had you before us, and today so far, that we have not made any mention of training. What plans do you have for training a prison doctor? Do you want any of them to obtain higher qualifications during their prison careers? How might this particular objective be achieved, in your view?

*(*Dr *Kilgour.)* The first thing to say is, of course, that the most immediate problem I had in this field was numbers and quality of people. When I arrived there just were not enough people to do the jobs—it was the Dutch boy scampering up and down the dam. Now we have got the recruiting side right, and I think the quality of those—that is, about 30 per cent of the total complement who have been recruited in the last two and a half years—is good. One of the outcomes of that is that we are in fact buying our specialisation. Again as I said to you before, with a lot of them I am either recruiting people who are qualified psychiatrists or who are general practitioners who have been principals for at least five years and have a good reason to want to change, or some with some special skill. For instance, two of them have come with particular knowledge of the drug abuse scene, and they are very useful as well. So you can buy skills and experience, but nevertheless the work of a prison doctor is itself a special skill, and that has to be taught. What we have been trying to do, and I think have done in the last few years, is that first of all they get a basic initial course which is very short, but it tells them something about what the Prison Medical Service is about. They are then attached, in the first instance—again in the past as far as possible, now much more as a matter of routine—to a large establishment where they will be taught by a senior medical officer and other more experienced medical staff around them. Then it is a question of deciding —and I *am* at that stage now—and saying that I would like to have in this group at least half a dozen youngsters in with bright, fresh ideas (one would hope), whom one would want to encourage to take higher qualifications from within the service. We have actually two of those right now. We did have three, but the third one has just got a higher qualification, so she has just moved up. So this is an actuality. It is not just an aspiration, it is actually happening. They are very high-class chaps. One is at Stafford, one is at Manchester, and the lady who has just qualified is down at Bristol. I am sorry, there are four: there is one at Cardiff too. They are very good. So that is at that level. Then, quite clearly, I think we should obviously have as much interchange inside out and from outside in of trainees as is possible. We do have quite a number of senior registrars coming in, but one of the problems about people from the inside going out is that obviously if you are going to do a job, shall we say, in a teaching hospital or on an outpatients' ward of a hospital, the people from the hospital want Doctor X from the Prison Department to arrive every Wednesday afternoon at two o'clock, in order to do the clinic. Regrettably, with an operational service, that is the sort of thing that is not always easy to do, that somebody will be able to come out at a specific time, because the needs within the service may override his ability to go, and it does make life difficult. That does not mean to say that it should be not tried. I am all for it, and I would like to see more and more of it.

438. Thank you. Can I move on to this

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sensitive area of infectious diseases? First of all, I would like to deal with hepatitis. In questioning prison medical officers about infectious diseases during some of the visits we have already made to establishments throughout the country, we have been surprised to hear that hepatitis, in the view of many, is not felt to be a major problem. I therefore put it to you that the prison medical statistics for 1984–85 show (and I am quoting here) 240 known carriers of hepatitis B, 152 cases of acute hepatitis B and 36 cases of acute hepatitis A. Is the Prison Medical Service coping satisfactorily with these cases, and do you need more isolation facilities to continue to deal with them satisfactorily?

*(*Dr *Kilgour.)* Can I start it off, then hand it over to Mr Barker. The statistics on the epidemiological side ought to be put into some sort of perspective first. One has to realise that hepatitis B is a very much more infectious disease—much more infectious than A—and it is spreading not only throughout the Western World. However, we are here in a "vicar's tea-party" in this country. We think we are menaced, but the carrier rate in West Africa is something like 30 per cent, the carrier rate in Turkey is 18 per cent, and it is rising in both places. Of course, there are specific ways of catching it. You can catch it as a venereal disease, because it is transmitted in semen. It is a particular scourge of the intravenous drugs misuser, because you can catch it off infected needles and so on. There are all sorts of body fluids and body contents which make hepatitis B a very infectious disease. For those cases whom we know to be carriers, there have been restrictions which are well known in the prison system among the discipline staff as well as among the medical officers, which are known now as the virus infectivity restrictions (for reasons which I will explain later, if you want). These seem to work very well. 269 is really, I would guess, a considerable underestimate of the real numbers, because there are many more going around who are not identified in prison or the population at large. There may be two or three of us in this room who are carriers, without realising it. If you have had a holiday in the Tropics, it is not unlikely that you would have been bitten by a carrying mosquito, without your necessarily having to have had jaundice. I am not being complacent about it; I am merely saying that what we do do I think indicates that the disease is not being transmitted to any significant extent by what happens inside prisons. But we are aware of it, and if there *were* signs of that happening I would want to know about it.

*(*Mr *Barker.)* Can I say that within the 24-week initial hospital officer's course and the induction course for prison nurses, we do emphasise the problem that there is in looking after patients with hepatitis B, but we can only touch on it in that very short time. We do encourage staff to attend training seminars outside in the Health Service, and they can obtain a lot of their information on the condition from there. But we *do* encourage them to partake of courses outside.

439. Thank you. Now could we move on to the emotive infectious disease of AIDS? Could you tell us a bit more about the Prison Medical Service's plans for dealing with the anticipated number of prisoners or inmates likely to be suffering from AIDS? Are you co-operating, for instance, Dr Kilgour, with the National Health Service in these plans that I hope you are making? How easy is it for prison medical officers to make use of NHS laboratory facilities, for example, in dealing with this scourge of AIDS which is besetting the world?

*(*Dr *Kilgour.)* Can I say at the beginning of the answer that I was one of the first people in WHO to hear about the discovery of AIDS and its significance in 1981, because I was chairman of the International Committee for the Surveillance of Communicable Diseases, and it was part of my job. Therefore, I have a very keen interest and, shall I say, my contacts with the international scene and the national one on AIDS are very close indeed and very fresh. I am surprised, and have been surprised, that we have not had in the prison system a considerably larger number of cases of AIDS than we have had. We have had actually one reported so far, and there are two people inside the system at the moment who have a pre-AIDS state. The one who actually had AIDS is dead. He was in for a very short time on remand. He died at the Hammersmith Hospital. He was an Italian drug-runner who was also an intravenous drug misuser himself. He died. The plans for dealing with AIDS are these. We have, as I have indicated, very few cases of AIDS, the actual syndrome itself, but only 10–20% of those who are sero-positive will develop the full AIDS syndrome. There are many more 'well' anti-body positives than obvious cases. That makes for considerable problems, problems of handling, problems of confidentiality, problems of education not only of staff but of inmates. So on all

[Mr Winterton *Contd.*]

those fronts we have had to do something very positive and very effective. It *has* been effective so far, because while we have had threats of industrial action due to, shall we say, over-reaction, due to ignorance of how AIDS is passed and how you contract AIDS, by staff and inmates, in other countries, in the United States and recently in Belgium, for instance, there have been riots which have caused millions of dollars worth of damage. There was one in Liege which was very upsetting, because of hysteria on the part of staff and inmates. The system we have had, of going round and talking to people—I have done a lot of this myself—has, I believe, controlled it and kept the lid on. I anticipate that in terms of actual cases of AIDS the prison system will probably have half a dozen by the end of this year; and that there will then be an increase, because of the disproportionate representation in the prison population of the high-risk groups (that is, of course, homosexuals, homosexual prostitutes, intravenous drug misusers, and then there is a small proportion of those very unfortunate people who are the haemophiliacs who have been given contaminated factor 8 and factor 9). I am told, incidentally, that there are 4,800 haemophiliacs in this country, and two-thirds of those are sero-positive. That is one of the tragedies. There is a very interesting point of confidentiality which arises here in relation to prisons. You will know about this from your visits.

440. Could I intervene and put another question to you, because I think we might then save covering the same ground twice? Have you considered making provision for routine blood tests on all inmates in prisons? We were told at Styal, which is one of the prisons that we visited, that routine blood tests *are* made of all inmates. Putting it together with that question, in your view—and could you explain it to the Committee—how could routine blood tests be done for AIDS, if the prisoner's consent is required? Please advise also—because I think this follows on—about the nature of the prisoner's *informed* consent (and I use that phrase purposely, following what you said earlier) for an AIDS test, especially when a positive result, even a carrier state, may be recorded on the inmate's record and disclosed to other persons subsequently, without the prisoner's consent.

(Dr *Kilgour.)* On the last three occasions when this subject came up, one of which was a television discussion programme and another one was a grand round at the London School last week, it took two hours to cover this particular set of subjects, so you will forgive me if I am grossly compressing! It is very important. Perhaps I could just finish what I was saying before. I expect to have a certain number of AIDS cases. I do not regard them as very infective at all. Frankly, from the point of view of making sure that there is no over-reaction by staff or inmates—which is a very diminishing thing, in view of the public education process that we have done, and successfully I think—we are building a new isolation facility in Brixton which will have room for 12, which will have it own sanitation and which will be regarded as an isolation unit. I intend this to be used for those cases of AIDS who are well. The well cases of AIDS are something I should explain. The mean time of survival of cases of AIDS, who are going to die of a particular kind of pneumonia which they tend to die of (this is one of the main causes of death), is that they survive for about nine months. During that time they probably have three episodes of pneumonia. If somebody is in the community, they will go into a hospital or a special centre each time they have pneumonia. When they are cured from it or made better, they will be discharged from the hospital. If it happens that these people are in prison at the time, we obviously have to take them back into the prison. I have to have somewhere to put these people, and that is what this facility at Brixton is going to be for, for what I call the well AIDS cases. Some others, and another equal number, will die from a thing called Kaposi's sarcoma which is a nasty form of skin cancer which can also go to the brain and other organs in the later stages. These people tend to live longer; they live for about 31 months—that is the epidemiological mean—after they have been diagnosed. They may have five or six episodes which require them to go into hospital, and then they come out again. It is for these people that I am providing these facilities in Brixton.

Chairman

441. Is that going to be enough beds?

(Dr *Kilgour.)* It will be for the next two or three years, because 80 per cent of the cases at the moment are in London and the South-east, and most of these are going to show up in the remand population, so Brixton seems to be the place to put them. But we are preparing similar isolation facilities in other establishments. These would be, for example, at the remand centre

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in the North—Risley. We shall have two or three what I call normal long-term prisons which have facilities which we can adapt towards isolation foor suitable cases.

442. These have not yet been designated? *(*Dr *Kilgour.)* They are not designated yet, because there is no need for them, but when we do designate them they can be switched over extremely quickly. It is my advice to all prison medical officers that it is a matter for independent clinical judgment whether or not they look at a person who is a member of a high-risk group and they think that that person should have a blood test done. However, they should discuss with the individual what the blood test will tell them. In other words, it will tell them that they have been exposed to the virus; it does not mean they are going to get AIDS or the full-blown syndrome. One in 10 will, and we have no way at the moment of knowing which 10 per cent are going to develop AIDS, so we have to regard all of them as people who may potentially develop the full-blown syndrome, and of course we have to regard them all as infective. That is the first step, therefore. It has become clear, at interdepartmental meetings—you did ask me whether I was collaborating with other Departments, and of course I work very closely indeed with the DHSS, if one may say so, on a collegial basis, because they know of my previous experience in Geneva—that there are penalties to knowing that you, as an individual, a patient, are HTLV3 positive. For instance, it is quite clear in America, and I have no doubt that it will happen in this country soon, that there will be penalties on getting life insurance, there will be penalties therefore on a knock-on basis for getting mortgages, and there will be problems along these lines, which I think will emerge in the fairly near future. They will undoubtedly stimulate discussion with the public education campaign which is due to start on 1 March, which is being run by the DHSS and which I welcome very much. You will see from that that I have reservations about one thing: that you do not do this blood test without consent, and that you try to make it as informed as possible. That means explaining to the individual what the social penalty of knowing may be, as well as what the advantage to them may be; because the test at the moment does not help the individual, but of course it will help the community, provided the individual is altruistic enough to want to change his lifestyle so that he ceases to be an infective danger to the rest of the community. So again, in my view, there is no question in the prison system of a routine taking of blood tests.

Mr Winterton

443. You do not think that the *community* interest should be weighed more heavily than the individual interest?

*(*Dr *Kilgour.)* Yes, as an epidemiologist, of course I feel that way, and I feel very strongly that we should know. How else can we ever know how quickly the infection is spreading? I am sure that this is true. But I believe that in the prison system, there it is very important that no medical nursing procedure, especially one that could be regarded as an invasive procedure, should be undertaken which is not for the benefit of the individual concerned. I have been applying this fairly harshly in terms of research as well as in terms of treatment. That is the guideline by which I measure things, while other parts of my experience tell me how important it would be and how desirable it would be to do some other things from the point of view of enlarging knowledge. I do not believe that the captive prison population is the appropriate population on which to start.

444. But you do not think that Government should go wider? There has been some compulsory vaccination and inoculation. Do you think that this sort of plague situation that *might* develop would justify that action?

*(*Dr *Kilgour.)* My answer to that has to be that in terms of my present job I have, I think, specified my own position. If you ask me as an individual, as a doctor and as an epidemiologist, what is going to happen, then I would have a very open mind about that. I believe that once the public are educated to a realisation, in the present state of knowledge, of how little we can do to cure this disease, that the only method of control is in fact a change of life-style, public education and the developing undoubted evidence of heterosexual transmission, which is very alarming indeed, then I believe that the public and the legislators may have to face a demand from the public for protection along those lines. However, I would not like to see the Prison Medical Service in the lead in this field, for obvious reasons.

Chairman

445. Could I put one question, Dr Kilgour, about your views on the management

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structure of the Prison Medical Service? Do you have any views about placing the Prison Medical Service under a special health authority, or do you have any other ideas about any other options? Do you think that the DHSS could manage the special hospitals and the Prison Medical Service together? Could you tell us about that?

*(*Dr *Kilgour.)* Yes. It is again a wide issue. My reply will be very compressed, and therefore I may not do it complete justice. I see, and give full weight to, public anxiety that a public service such as the prison system as a whole and the Prison Medical Service within it should be clearly accountable in terms of the quality of the service that is offered, and its accessibility at appropriate times to all the individuals inside. Because of the way that it is set up, I see that this arouses legitimate concerns among people that this may not be happening, because it is different from the NHS. I may say here that again another yardstick that I use is that the service we give must be as good, from a quality point of view, as what could be available to the individual outside, otherwise something needs to be improved. I am not saying that it *is* right everywhere, but as soon as I recognise that it is not, that is cause for remedial action. How to achieve it? It is my feeling that there has been perhaps too much worry about the structural argument and not enough worry about the quality argument. In my view, it is a very legitimate concern of the public that the quality of the service should be looked at; people should feel confidence in that. The argument over the last 20 years, whenever this has come up before, has always got sterile, because they have strained at the structural side of it. The fact that it is being run by the Home Secretary or the Secretary of State for Social Services—that to me is not the important thing; it is the question of whether there is some way of measuring and assuring that the quality of the service, medical and nursing, is as good as what you would find in the NHS, or better than what you would find in the NHS. There are very considerable, if not insurmountable, operational management, administration—whatever word you want to use—difficulties in taking the Prison Medical Service out of the control of the Home Secretary who is statutorily responsible for the whole of the prison system. If I may say so, it would be like taking the Naval Medical Service out of the Ministry of Defence and putting it onto the DHSS. There is a parallel in that. So not for quality reasons but for administrative reasons—and perhaps political, statutory and other points like that—it would be difficult, I think, to take it out. However, I do not think that that is necessarily the only way of doing it. The thoughts that have been going through my mind in the last year have been whether or not one could not interest, or arouse the interest of, those bodies who have, as part of their *raison d'etre*, a responsibility for the professional attainment and the experience that ought to be had in various professions. I am thinking of course of the Royal College of General Practitioners for GPs, and the Royal College of Psychiatrists for psychiatrists, the Royal College of Nursing for nursing, and so on. So the thought that has gone through my mind has been—and I have carried it beyond that—as to whether or not there could not be a grouping of such interests who could meet together, perhaps as a standing committee or something like that, quite separately from the Department of Health, quite separately from the Home Office, although with representation on them, who could from time to time opine on the standards that ought to be achieved by prison medical officers, prison nursing officers, in order to ensure that the standards are maintained. They should be clearly seen to be separate and independent in their views, and be so composed as to be beyond question in terms of the value of their opinions. There is a movement under the aegis of the President of the Royal College of Physicians, to put a motion to the Conference of Colleges in London in the fairly near future, on just such a proposal. If that were to come, I would welcome it very much. It may not be the only way ahead, but it does seem to me to offer a way forward which I do not think anybody would oppose. This would therefore go some way to giving at least public assurance of quality of service.

Mr Galley

446. That would be more a consultative and advisory body rather than a management body?

*(*Dr *Kilgour.)* Consultative, advisory, yes.

Chairman

447. The Mental Health Act Commission has been wanting to inspect the prison hospitals. Would you welcome that sort of outside inspection?

*(*Dr *Kilgour.)* Yes. The difficulty there is one of the terms of the establishment of the

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Mental Health Act Commission. A lot of friends of mine are members of that Commission. I have seen some of the work that they have already done, including the draft code of conduct (a very weighty document). I think that their advice would be very useful, particularly if we start to move towards establishing special units for those who are mentally disordered within the prison system, but who are not within the criteria of the Mental Health Act. Of course, the Commission is really set up to oversee the conditions of the approved places, the appropriate places, of which the prison system is not one, and I would not seek that it should become one because I think that that would be a very backward step, since it would then make it appear that prison was a good place to send awkward people who were mentally disordered, and that is perhaps not something we want to encourage.

*(*Mr *Barker.)* May I make a small plea about the accountability of nursing staff within the service. It would be nice to think that a professional qualification in nursing would mean that nursing staff would be accountable to a professional body. At present they are not accountable to a professional body. I would like to see—and I am sure Dr Kilgour would—more professional responsibility and accountability for nursing staff, and that includes hospital officers.

Mr Galley

448. Can we turn to the matter of drug dependency and, to some extent, alcohol dependency? The Select Committee, in its Report last year, was very keen on the idea that with drug addicts and abusers in prison we could take the opportunity to try to help them in the longer term. The information that we have had on our visits is that generally it is a case of immediate withdrawal, probably on remand, for drug misusers, and there is very little other attempt to assist them. Do you think that that is satisfactory? Is that the right way of dealing with the problem?

*(*Dr *Kilgour.)* The answer is that it is *not* satisfactory. I can give you some indication of what we are trying to do to make it better. Can I say first of all that I think that there is a great deal of misunderstanding, often with good intentions, both within the medical profession and outside it, as to what the responsibilities of the medical profession in this are. Perhaps I can briefly say what I mean. I believe that it is very clear that it is a medical responsibility to withdraw a drug addict from his drug of addiction, and to do it in as safe and quick a manner as possible. It happens that the prison system is one of the bright spots, in this part of dealing with drug addiction, because in the prison system you do not —although I concede there may be occasional cases where it is advisable, but in the vast majority of cases you do not—have to withdraw them from their drug addiction by supplanting it with another addiction, which is what methadone substitution, in my view, is. So within the prison system you can deal with this, because you can keep them under constant observation, give them the support that is needed during withdrawal, which can be done much more quickly than in the community, again for obvious reasons. That is the lack of temptation of getting supplies of drugs to such people, say, who are in a hospital room at the time usually; it puts the possibility of getting it out of their mind, and it makes the withdrawal easier. This is where I think that there should be two schools of thought. Regrettably, there is often only one, and it is wrong. There is the feeling that it is a medical problem to keep that addict off his drug addiction. In my view, it is not. Obviously the medical services should do all that they can, whenever there is an appropriate way to do it, to support the social service and the individual in the attempt to keep them off the drug, but this is a personal social service and an individual decision, it is not a thing that can be done by the medical profession. I think that an awful lot of the failure that I see is because the medical profession overaspires in this particular problem. We ought far more to bring in the social service support and be working on the individual as far as that is ever possible. That is an unrewarding, uphill task. You can see what it is like to try to make people stop smoking cigarettes or stop drinking alcohol. The result is that we have an incompetent group of people trying to do a very important part of the job, and they are sitting there as "Aunt Sallies" for other people to blame for the failure when it does not work. My response to this is that we need much more coherence in the organisation of throughcare in the prison system for these people. At the moment—and I accept this as a criticism, because I join the criticism myself—we are very good at getting them off, but the follow-through is not very well done, or at least not well done everywhere.

Chairman

449. If you want follow-through, you would have to get in touch with their general practitioners and their social services departments, wherever they are going to?

*(*Dr *Kilgour.)* That is right.

450. You do not always know where they are going anyway, do you?

*(*Dr *Kilgour.)* That is absolutely true. The first step—and we have just taken it—is to involve the probation service within the prison. The seconded probation officers (we have 500 of them within the prison system) can be, I hope, an effective bridge into the community with the individual who consents to take advice from them. The next thing to say is that I was surprised when I first came into this, from the prison point of view, talking to directors of the drug centres in the community, as to the unanimity with which they told me that the worst place in the world to send somebody who has been withdrawn from his drug addiction is to such a drug centre (that is, assuming that you can get over the waiting list that some of them have). They say that if they do go there they are reintroduced to the drug scene. Often (not in all cases, but still often) the second thing they are met with is a prescription. In other words, it is a backward step. Somehow I want to start the positive move to a bridge from inside the prison system, to make sure that the inmate, when he goes out, has advice in his hands of where the nearest drug centre is, the name of the individuals, telephone numbers, addresses and so on, where he is going to go or where he says he is going to go. He takes that with him, but it is his decision whether or not he goes to them for help. I think that is important, because it has to be a personal decision taken without constraint. If they leave in the infantile state, they go on as an addict. It is very difficult indeed. But I do believe that we are beginning to improve things. I cannot say more than that, because I think the track record of success in this field is abysmal.

Mr Galley

451. Assuming that you can establish that counselling service and the follow-through, do you think that it is acceptable and not too traumatic for the drug misusers themselves to be withdrawn so quickly from the habit? Would you in no circumstances countenance methadone substitution?

*(*Dr *Kilgour.)* I have to say again, one always has to come back to square one in these things. How the addict is removed from his drug addiction has to be an individual matter for the individual professional judgment of the doctor concerned. I can say to you, however, that more and more now the overwhelming majority of those within the service recognise the conditions of custody and see the advantages custody gives you in this particular case, and they find that this is by far the best way and the most humane way of withdrawal, because it is all over very quickly and with much less trauma emotionally and physically than a lot of people think whose contact with it is the lost weekend or something like that; it is much less than that. This is anecdotal, but I do go out of my way to talk to inmates, where I can find them as I go around, who have been drug addicts. The unanimous verdict is that if only that could have been done for them in the community. They are often intelligent people, and they recognise that it would not have been practicable, it is only in prison that one can really do this safely.

452. Is counselling and advice going to be effective, do you think, in many cases? It is often a problem of the environment in which people find themselves; that is why they get into a drug culture. If they go from the prison and return to precisely that environment, are not they likely automatically to go back into the habit?

*(*Dr *Kilgour.)* Yes, I am afraid this is part of the problem. All I can say is that from the prison side I recognise that, and I have to say it to my colleagues in the NHS and in the community. But what else can you do? If you release somebody from prison, they obviously go back home for the most part, or to their familiar haunts if they do not have a home. Those haunts will include the same environment that originally got them onto the drug. It is a *very* difficult situation.

453. Long-term rehabilitation to a large extent seems to depend on building up self-esteem, self-respect, which presumably is very difficult to do in a prison environment?

*(*Dr *Kilgour.)* Yes. I hope that when Mr Barker is able, in the course of the next two years, when we have a real sea change in the terms of the numbers of qualified nurses that we have, these will be a profoundly important resource in dealing with these people, at least in the early stages. But it is the maintenance of the addict free from his drug problem, and we just do not have the time and the people to do that. I think this

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has to be done, as I say, on a personal social service basis. The probation staff seem to be the obvious people either to do it themselves or to bring in other people to help them to do it.

Chairman

454. I think we have to leave that there now. I would like to put some questions to Mr Barker now, who has been very patient. Can I ask you what problems you anticipate in phasing out the nursing grade? We have had quite a lot of input from people whom we have met on our visits recently, where nurses have expressed to us their fears that as a consequence of the changes in nursing arrangements that you are planning, they will have to be answerable to hospital officers who have no formal nursing qualifications. Will you be able to guarantee the professional position of nurses currently in the prison service—because there is some concern about that?

*(*Mr *Barker.)* I am well aware of the concern that has been expressed by nursing staff, but I would hope that in the first instance we would only recruit qualified nurses to fill vacancies and increase the staff in post in female prisons. In other words, as we phased out the nursing staff, then we would introduce female hospital nurses who would be qualified. So there would be no change in the responsibility that that particular person would have; they would still be a professional nurse, albeit they will have an extra module of training which would be in discipline matters. However, as regards their professional qualifications, they would stay the same although the name would change.

455. What has been the Prison Officers' Association's response to your proposals?

*(*Mr *Barker.)* The Prison Officers' Association are very excited by the prospect of our introducing into the hospital officer grades a higher level of qualified nurses, and they support us wholeheartedly.

456. Is there going to be a further extension of *their* initial training course?

*(*Mr *Barker.)* The hospital officers?

457. The hospital officers, yes.

*(*Mr *Barker.)* What I would like to see is the opportunity for hospital officers that are in the service at the moment to take advantage of training and become professional nurses. However, one could only work to a certain level, so the other avenue available, and which we are considering at this particular time, would be some sort of structured arrangement for hospital officers below a registered qualification. If one were to take as an analogy the Armed Forces, one could think of different grades of hospital officer who were rewarded for their particular attainment, with the final grade being a registered nurse. I am well aware that there are quite a few hospital officers within the service who would not want to go for the full training, and I think that the experience of that particular type of officer is invaluable within the service, and I would not like to have to lose him.

458. Then how long would that training period be?

*(*Mr *Barker.)* At the moment the initial hospital officer's training is 24 weeks. I would hope that after three years we would then bring the officer back, to introduce a high level of training, and that we would also introduce a professional, vocational type examination which would then better equip the officer for a higher level of attainment within the service.

459. Yes, but what would that additional training period be?

*(*Mr *Barker.)* At this particular time we are only just discussing it.

460. In Scotland I think it is two years, is it not?

*(*Mr *Barker.)* In Scotland officers are trained to enrolled nurse level, and in Scotland it is an 18-month course. In this country, for an enrolled nurse, it takes two years, but I do know that in the Scottish Prison Service it is an 18-month course. I am not convinced that one needs to have the whole of the hospital officer service staffed by qualified nurses, however. I think there needs to be an increased percentage, but there is still a necessity for hospital officers of a lower attainment.

461. There seems to be a considerable difference in the staffing arrangement for men's and women's prison hospitals. We understand that in women's prisons it is possible for agency nurses to be recruited to fill temporary vacancies; but that hospital officers have to work more overtime when they are short-staffed. Have you considered recruiting agency nurses to work in men's prison hospitals when they are short-staffed? Would that be a good idea?

*(*Mr *Barker.)* On the face of it, it would seem to be a good idea, but unfortunately because of the level to which hospital

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officers are trained, and the level of agency nurses—and all agency nurses are qualified nurses—we could not introduce them. I am sure that the Prison Officers' Association would not agree to our employing agency nurses to replace hospital officers.

462. Is that on grounds of payment?
*(*Mr *Barker.)* Not on grounds of payment, no, I would not think so, but on grounds of attainment. Also they would see this as the thin end of the wedge; that perhaps we would introduce agency nurses, at the expense of their members, to fill the gap.

463. But I understand that in the Health Service agency nurses get paid at a higher rate than trained nurses do, which causes some anguish in the hospital wards?
*(*Mr *Barker.)* No, I do not think that is quite true. I think agency nurses are paid the same rates that nurses are paid. I think it is the agency that gets the extra money, and not the nurse herself.

464. That seems to me an even more gross waste of money.
*(*Mr *Barker.)* That is so.

465. To what extent are hospital officers trained in dispensing drugs? Do you think that this part of their training should be extended?
*(*Mr *Barker.)* Hospital officers do get a training in administering drugs. I think the type of training that is given is adequate for the type of work that they do. We try to ensure that wherever possible two members of staff are available to check drugs, but this is not always possible, due to the shortages of staff that there are. I do think, however, that they receive adequate training, and there are safeguards to prevent accidents happening. To the best of my knowledge, I am not aware of there being any criticism in the way that hospital officers administer drugs to inmates.

466. We have received some evidence, Mr Barker, which is a matter of concern if it is true, suggesting that X-rays are sometimes taken in prison by staff who are not properly trained to do that. This of course can be very dangerous both for those who are doing it and for the inmates. What training do hospital officers receive in radiography, and do you think that it is adequate for the job they have to do?
*(*Mr *Barker.)* At this particular time we run a very short course on darkroom techniques. During that course there is an input on X-raying extremities.

467. How long is that course?
*(*Mr *Barker.)* Two weeks. When I say "extremities", we are only only talking about hands, wrists and feet, and accidents that are likely to happen to those areas. However, to introduce radiographers into some of the smaller establishments where there might only be one accident a week, would seem to be a waste of public funds. I would think that the hospital officers that do carry out these limited investigations are qualified to carry out that procedure, which is only a minor procedure.

468. It depends, does it not? It may not necessarily be minor.
*(*Mr *Barker.)* I would not expect a hospital officer to undertake any sort of X-ray which was not of a minor nature.
*(*Dr *Kilgour.)* Perhaps it might be appropriate to say here—and what I am going to say is an intention during this year, this has not happened yet—that the intention is to go to the Faculty of Radiologists and then to the Society of Radiographers, to put to *them* the problem that we have: that we need to have a facility to do minor X-rays, within the prison establishment, with the simplest kind of machines that we can have, and what, in their view, would then be the shortest form of training to make an operator safe with the machine.

469. When do you expect to conclude those discussions?
*(*Dr *Kilgour.)* During this year.

470. The alternative, of course, would be to bring in radiographers from the Health Service, as and when they are required?
*(*Dr *Kilgour.)* Yes, which is either hugely expensive or expensive in terms of escorts having to send the prisoners out to the hospitals.

471. Or bringing the radiographer into the prison?
*(*Dr *Kilgour.)* Yes. Because they are often not close to each other.

472. Clearly it is a problem, is it not?
*(*Dr *Kilgour.)* It is.

473. We shall look forward to seeing what recommendations you make. During our visits, Mr Barker, we have heard criticism of the slowness of the Home

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Office's recruitment procedures both for nurses and for medical officers. I am sure you have heard it too. We have been told that it takes up to six months to vet candidates. One cannot think that the Department thinks it is very urgent to get any candidates, if that is true. Is it true, is it correct? Is it necessary for recruitment and checking to take so long? Is not there a very serious risk that if it *does* take so long, you may well lose some very good candidates who get jobs elsewhere in the meantime?

*(*Mr *Barker.)* That is perfectly true, yes, and I can agree that it does on occasions take six months and that we do lose valuable material, because in the job market people are looking for work and the first job that comes along they take.

474. Do you have any idea why it takes six months?

*(*Mr *Barker.)* I made inquiries this morning as to why it took so long, as one of the staff that deals with recruiting happened to be with me. We first have to ask for permission to recruit, then put forward an advertisement. We then have to wait for people to reply to the advertisement and send forms of application which have to come back to be vetted. We then have to short-list candidates and set up a board. Once the board has sat, then we have to notify the successful candidates, offer them the post and at the same time take up references. One has to look at whether they, at the end of the day, would be willing to join. So it does take a long, long time. A ray of hope is on the horizon at the moment, from my point of view; we have been offered and given a clerical officer who will deal solely with nursing staff. Also I understand that in the near future we are hoping to introduce computers into that particular section.

475. I do not know what the computer is going to do. You cannot interview people with computers!

*(*Mr *Barker.)* Provided the computer does not fail, it should speed the selection process up.

*(*Dr *Kilgour.)* I have had the same problems with medical officers, but of course the numbers are small. On my side of it, with the personnel, we have the Civil Service Commission working fairly well on it, and we are down to no more than three months now. That is the time that anybody we recruit has to give notice and so forth to his present employer. But it is still too long.

Mr Galley

476. Are you happy, Dr Kilgour, with the provision of pharmacy services within the Prison Medical Service?

*(*Dr *Kilgour.)* I think it works really very well. In the context of the prison system, we have got 16 pharmacists, or we have posts for 16 full-time pharmacists. We have actually got 14 in post, and three part-timers. There is one vacancy. We have also got a number of pharmacy technicians, which is the way that the NHS has gone over recent years (and very successfully, I think). They are very valuable people and do the job very well. The prison system also has a unique person called a compounder. He is a sort of pharmacist's assistant, one would call him. This developed from long ago. The compounders are trained in a way which is now becoming more and more close to the pharmaceutical technician. However, in the last two and a half years we have not recruited a compounder. That may carry a message. The policy now is to have pharmacists and pharmaceutical technicians, but we do have in existence 46 of these very experienced compounders some of whom have been doing it for many years and are reliable, working under the supervision of course of a qualified pharmacist, sometimes not having the pharmacist next door to them, but a pharmacist visiting them from a neighbouring larger establishment. Nowadays more and more we get our pharmaceutical supplies coming—as in the NHS—ready-packaged, with the doses already made, and the pills are in strips. The dispensing side of it is a much less arduous task than it is in an NHS hospital; there is a much greater degree of standardisation. The answer to your question is "Yes and no", therefore. I am content with the work the pharmacists are doing. I am content with the work that pharmaceutical technicians are doing, and I would like to see as many as possible of the compounders taking the pharmaceutical technician qualification, which they are encouraged to do. That is the state of the game.

477. In terms of the pharmacists, the establishment has not changed very much in 10 years, has it?

*(*Dr *Kilgour.)* No.

478. As you say, you are under-establishment at present. How are the staffing levels of the technicians and the compounders?

*(*Dr *Kilgour.)* They have stayed roughly the same; I do not think there has been any great growth. There is no doubt there has

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been an increase in the population they serve. I have taken steps to try to suggest that an increase would be desirable. The response has been that perhaps the pharmacy group have become more efficient over the last few years, because they have coped so well with the increase in population. I am not saying that lightheartedly; that it a general situation or a general position.

479. Presumably the pre-packaging that you are referring to eases their job?

*(*Dr *Kilgour.)* Yes, I think so. What I am really saying is that it justifies more the role that compounders have than one might otherwise think. I think that 20 years ago one could have made a greater criticism perhaps of the amount of professional skill a compounder might have had related to the responsibilities that he carried. It is easier, in other words, to give doses or to follow prescriptions, because of the nature of the way that the prescriptions are put up nowadays.

*(*Mr *Barker.)* If I may say something about compounders. Compounders all started off as hospital officers; unfortunately, when he does his compounding work he is a loss to the nursing side. So the hours that the compounder spends in a pharmacy are a loss, from *my* point of view, to the nursing staff. It does create a conflict of interests.

Mr Lewis

480. On the financing of the dental services in prisons today, it has been suggested that there is a fixed budget for dental work in each prison, and that dental surgeons are unable to provide treatment because if they do they would exceed their budget. Would you say this is correct? Have you had any complaints from dentists or inmates about the service?

*(*Dr *Kilgour.)* The answers to your questions are that it is not correct, and I have had complaints. Let me put them both together. There was a recent case, which is receiving a ministerial written reply tomorrow, about Hindley. There has been a problem there with a governor who is trying to live within his budget for the year, and a dentist who arrived fairly recently there and is a very conscientious operator, who has been there and doing anything that he feels needed to be done on the inmates, quite correctly. He was told by the governor, who was running out of the amount of his budget that he had allocated for dental services, that he would have to cut down the number of clinics. The case has come to th Medical Directorate. We have increased th budget, because this is centrally controlle Therefore, the dentist is now aware that h can go ahead and give whatever treatmen he considers to be right, necessary an desirable, from a professional point of view to the inmates. I would like to add that h has entirely agreed with the fact tha perhaps he was commencing treatment which he could not always guarantee t complete, because the patient might be o the move, and he was therefore startin something he could not complete. So fairly good compromise has come through But the principle behind it is that ther should be—and as far as I am aware ther is—no case where somebody is denie treatment which he would have been give had he been outside in the community from NHS sources, giving as a reason, lac of resources. In other words, there ar budgets, but they are target budgets no ceilings.

Chairman

481. Dr Kilgour, positively the last ques tion to you. Do clinical psychologists em ployed in prisons play any role in the Priso Medical Service?

*(*Dr *Kilgour.)* Yes, they do, and it is a issue which is under active discussion at th moment. There are in the prison service a the moment, I believe, 119 psychologists. A very small percentage of those are clinica psychologists. Indeed, at one point ther was only one. There are now about seven o eight. Psychologists as a whole broke awa from the administrative arms of the Priso Medical Service some years ago. In the ligh of the kind of psychologists they were, an the kind of jobs that they like to do, I thin it was right that they should break away because very few of them were clinica psychologists—not therapists in that sens of the word.

482. They are rare birds anyway, ar they not?

*(*Dr *Kilgour.)* They are, yes. Curiously the Civil Service has not got a grade for clinical psychologist. A clinical psychologis would get paid a bit more. So if a psycholo gist in the prison service qualifies as clinical psychologist, he tends to go out int the NHS. I have done a very rough estimat that the medical service can use the service of about 20 full-time equivalent clinica psychologists over the prison system mainly in the local prisons, the reman centres and the long-term dispersal systen

[Chairman *Contd.*]

prisons. All we really need is the time of clinical psychologists to do the work that we would like them to do. Whether they would be full-time employees of the Prison Department, or whether they would be hired on a sessional basis from the NHS, is immaterial to me, as long as I can have the time and the work done. That is my position. So if we were to do it on a full-time basis, then I would be very happy, and I think it would be quite appropriate for the clinical psychologists to rejoin the Prison Medical Service if that seemed appropriate. Chairman: That concludes our questions. We are most grateful to both of you. Thank you very much indeed for your help.

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HOUSE OF COMMONS

SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

Wednesday 12 February 1986

Women in Prison

Ms Chris Tchaikovsky and Ms Helen Moore

Rap/Inquest

Mr Tony Ward and Mr David Leadbetter

Ordered by The House of Commons *to be printed 12 February 1986*

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WEDNESDAY 12 FEBRUARY 1986

Members present:

Mrs Renée Short, in the Chair

Mr Tony Favell
Mr Roy Galley
Mr Charles Kennedy
Mr Ron Lewis
Sir David Price
Mr Tim Yeo

Extracts from a Memorandum submitted by Women in Prison

INTRODUCTION

WIP is a campaigning group comprising ex-prisoners and others, which has bee operative since March 1983. The main objective of the campaign is to remove complet control of prisons from the Home Office. This includes the abolition of the Prison Medica Service and its replacement by normal NHS provision.

We have received numerous complaints from women prisoners and ex-prisoner regarding their medical treatment whilst in custody, which confirm our own first-han experiences.

The case histories which follow are not isolated accounts; there is a marked similarit between the complaints reaching us from women in different prisons under varyin regimes across the country.

We have selected these cases for submission because they typify the most commo problems faced by women prisoners.

SECTION ONE: GENERAL MEDICAL PROCEDURE

Profile of Women Prisoners' Health

Women prisoners constitute only three per cent of the prison population in England Scotland and Wales, and perhaps because they are such a small proportion of th imprisoned there is little scientific study of this group.

One unpublished study based on examining the health of every fourth woman enterin Holloway in 1967 produced startling results on the general medical condition of the femal prison population.

Professor T C N Gibbens found that among women *remanded* into custody 15 per cen had a *major* physical health problem; 20 per cent had a *major* mental health problem; 2 per cent of the women studied had attempted suicide in the past; nine per cent suffere from venereal disease; 13 per cent were pregnant and 24 per cent had at some time bee prostitutes.

Among the sentenced women, Professor Gibbens found that 21 per cent had a *majo* physical health problem and 15 per cent had a *major* mental health problem.

It should be clear from this profile of remanded and sentenced women prisoners that th Prison Medical Service doctors have a very sick population of prisoners to treat and car for.

The cost of printing and publishing these Minutes of Evidence is estimated by Her Majesty's Stationer Office at £2,592.

Selected features of history or examination	Remand before conviction	Remand for medical report only	Remand after conviction for social and medical reports	Sentenced to imprisonment	Prison in default of a fine
	%	%	%	%	%
Physical ill health a major problem	15	18	16	21	21
Mental ill health a major problem	20	39	29	15	16
Inpatient in mental hospital since January 1964	14	26	21	17	16
Inpatient in mental hospital more than 3 years before	4	10	7	8	10
Suicidal attempts in past	21	26	23	22	29
Alcoholism	3	7	3	7	41
VD (gonorrhoea and syphilis	9	18	9	9	13
Pregnant now (0.66 illegitimate)	13	7	10	7	16
Past or present prostitution	24	30	24	35	62

Medical Records

Although medical records are normally processed by the NHS central register within six months, prison doctors do not have a medical history for prisoners except for those serving sentences of longer than two years. It is patently absurd to assume that prisoners serving more than two years would need their medical history with them in prison any more than prisoners serving less than two years.

There is a cursory medical examination on reception into prison, and recently a medical questionnaire was introduced which is filled in on admission. But as 14.5 per cent of prisoners have a reading age of less than twelve, and six per cent less than six years, clear medical information must be difficult to obtain.

During the period a prisoner serves a sentence s/he is often transferred to other prisons and "in many cases the medical officer may not know the inmate's destination on transfer, or even that s/he has been transferred" (Circular Instruction 22/84, Standing Order Amendment 373/84).

In addition, there is a reluctance to enter full details of medical treatment "because they are seen by non-medical staff, and because . . . there is a danger that they may be mislaid". This procedure has obvious and serious implications when monitoring for allergies.

So not only does the prisoner not have a continuous medical history, but she can have no continuous informed through-care during the period of her imprisonment.

WIP argues that it is extremely dangerous for prisoners to have no medical history whe they enter prison and no continuous medical history while in prison.

GENERAL PROCEDURE: MEDICATION

The case history of Emanuelle Piazza highlights

(a) the problem of confusion in prescribing between separate medical personnel withi the same prison, and

(b) the danger of removing from women prisoners all responsibility for their own health

Emanuelle was not allowed to know what medication she was being given, although near-fatal series of incidents could have been avoided if anyone had consulted with or pai attention to her.

Rita Pollard with a heart condition, was placed under even more stress because she di not know what medication she was taking, and had no way of being certain that she wa now being treated seriously.

These are not isolated incidents; many other women have complainted to WIP that the are not permitted to know what medication they are receiving, and it is a source o understandable concern to them.

In a declaration in 1977 the World Psychiatric Association stated:

"every patient must be treated with . . . the respect due to the dignity of all human being and to their autonomy over their own lives and health."

WIP believes that doctors working without medical records, with educationall disadvantaged prisoners who are not allowed to know what medication they are receiving should have the most stringent failsafe procedures for treatment.

SECTION TWO: "MALINGERING"

Almost a quarter of the sentenced female prison population enter prisons with a majo health problem, 12 per cent with a major mental health problem, and 21 per cent of th women remanded into custody have a history of attempted suicide.

Yet all prisoners are aware that no matter how ill they are they will be disbelieved, nc taken seriously and assumed to be malingering. This assumption on the part of priso doctors is a feature in all the case histories we have submitted.

The problem of not being believed by the prison doctor is compounded by the fact tha even before a prisoner can see a doctor, her application is vetted by prison officers an prison nurses. This vetting can have fatal consequences; Sarah Hewer was locked in her ce to die after twice being refused permission to see the prison doctor.

The dangerous practice of vetting continues today. WIP Campaign Demand 16 calls fo

The abolition of the present system where prison officers and prison nurses have the righ to vet a prisoners request to see a doctor.

SECTION THREE: HYGIENE, HEALTH AND SAFETY

Most prisons are filthy, and little or no encouragement is given inmates to be clean or t stay clean. At Pucklechurch Remand Centre women are put on report if they "sneak i twice a week" to wash their clothes, instead of the mandatory once a week.

Reports of mice, bedbugs and cockroaches in Holloway have been brought to WIP b ex-prisoners. The degree of infestation in this prison was thought by one woman to be contributory cause of the recent Holloway riot (June 1985).

At Pucklechurch Remand Centre (a prison without integral sanitation), rather than sleep with faeces in their cells overnight, women throw it out of the windows. This faeces is not always cleaned away during the day and remains under the prisoners' cell windows for some time. Throwing faeces out of cell windows is in fact common practice in all prisons without integral sanitation, but Pucklechurch is the only prison about which we have received complaints.

Local Environmental Health Officers have no jurisdiction within prisons because of the Crown Property exemption they carry. WIP argues that this exemption should be lifted to ensure the cleanliness of prisons, especially prison kitchens, and sanitation.

WIP asks:

Prison doctors are responsible for the cleanliness of prisons; why is so little effort made by these doctors to maintain levels of hygiene comparable to institutions in the community?

Why don't prison doctors resist a regime which actually discourages cleanliness?

Infestation, Holloway June 1985

WIP has been informed by ex-prisoners coming to the office that Holloway is infested with cockroaches, bedbugs, mice and rats.

When one prisoner, Jackie Beswick, complained to landing officers of cockroaches "as big as shrimps", they were insistent that she was imagining things, whereupon this enterprising young women collected four of them in her cell and placed the live evidence on her dinner plate which she handed through the hatch to one of the disbelieving officers, who beat a hasty retreat.

After continuous pressure from inmates on B5 (remand) about the cockroaches and bedbugs, a "fumigation" of the wing took place. The women were given an extra half-hour out of their cells, after which they were locked up as usual. Jackie Beswick complained that women were choking and feeling very ill indeed, while many of them developed rashes, including Jackie, who suffered a severe attack of eczema. She did not know whether any asthmatics were housed on B5 at the time. Jackie thought that the "fumigation" was carried out by male prison staff.

Another ex-prisoner, Gill Mebarek, informed WIP that there were rats and mice in the prison.

WIP asks:

Why didn't the same prison doctor who informed prisoners complaining of bites that they were from bedbugs, arrange for full and proper fumigation by Islington Environmental Health Authority?

Health: Diet

Prison food is often disgusting to taste and contains little or no nutritional value.

WIP asks:

Why don't PMS doctors intervene to ensure prisoners receive a healthy diet?

Health: Exercise

All prisoners should be able to take daily exercise *weather permitting*. Officers seem not to enjoy supervising exercise and often refuse to take women out if there is a hint of rain or if rain is forecast. Women can and do remain on airless wings for days. One woman serving a life sentence (now at Cookham Wood) is suffering from a skin disease due to lack of exposure to sunlight.

SAFETY (FIRE)

Prisons are dangerous. According to Fire & Safety News, a specialist magazine, "there i no place like prison for fire hazards." The one safeguard prisoners do have is that a fire i dangerous for everyone. The POA, not the PMS, pressed the Home Office to issue non toxic flame retardant mattresses in prisons and these will go some way towards improvin safety conditions. But the pillows in prisons are still made from material which is easy t ignite and burns rapidly.

Moreover, match splitting is still a feature of all closed womens prisons (exceptin Cookham Wood) where "wages" are so low (average £1.39 pw) women can only afford on box of matches a week. Match splitting is an extremely dangerous practice because smal slivers of burning sulphur fly everywhere. Any observant visitor to the prisons will notic small burn holes in women prisoners' clothes and bedding from these pieces of sulphur 'WIP has urged prison governors to permit safe lighters in their prisons; pointed out tha split matches are dangerous and that male prisoners are permitted lighters. To date only th governor of Cookham Wood prison has granted permission.

Many prisoners have expressed concern about the lack of fire drills in prisons, and hov or if they would be evacuated if a fire took hold especially at night. Holloway and Risle prisons have a particularly bad fire record.

WIP asks:

Why do PMS doctors sanction such dangerous conditions for their patients?

SAFETY (EMERGENCY BELLS)

A problem known to all women prisoners is that prison officers are reluctant to answe the emergency bells at night:

"they will not open your door after 8 pm so you could die . . .
they also have a silent block, a cell within another so you can't hear them . . ."

Pat Macfarlane
Pucklechurch

"The other women in the dorm kept ringing the emergency bell . . . but this was ignored"

Jackie Pearce
Holloway

". . . although the other women were ringing the bell and shouting for help it was a couple of hours before the PO came".

Becky Fitch
Risley

". . . she rang the emergency bell three times the response to this was that if anyone rang the bell again they would be put on report for it. The emergency bell was then switched off".

Anna
Styal

". . . it was nearly ten minutes before they opened her door. Smoke was pouring everywhere . . ."

M. Brown
Holloway

SECTION FOUR: VULNERABLE WOMEN IN PRISON

WIP argues that because of the inadequacies of the Prison Medical Service all women are vulnerable in prison. But some women are more vulnerable than others. For example Christine Scott, was a young prisoner with an eight year history of mental illness and "poo personality resources", Julie Potter had the mental age of a child, Maria Szigmund suffered

from severe depression, Sarah Hewer was highly disturbed, Yvonne Lepas entered the prison with a major health problem and Joyce Marsh suffered from epilepsy.

Other prisoners at risk are pregnant women, asthmatics, women on Durham "H" Wing, women who require drugs while in prison, mothers and babies and women who have no friends or families to support them. On C1 Wing, Holloway Prison, between January and June 1984, almost half the women had no outside contacts at all, particularly the older women.

Women Requiring Drugs in Prison

"As the BMA well knows from first-hand evidence, potentially dangerous psychotropic drugs are often prescribed, sometimes on a monstrous scale, without even prisoner-patients being examined."

(Editorial, World Medicine, 1982)

Women's prisons are invariably at the top of the drugs league. The Home Office has argued that this merely reflects the situation outside the prisons, but unlike their male counterparts, women prisoners have few facilities (e.g. gymnasia, education, work, leisure) and are locked up for longer periods of time. There are two expressions which sum up many prisoners' attitude towards drug-taking: "Do your time on your pillow" and "Sleep your time away".

We have no evidence of forcible drugging in any women's prison. There is, however, an element of coercion in ensuring that drugs are taken once prescribed. For example, in Bullwood Hall and Holloway women who are placed on wings where matches are not permitted have informed us that they are refused a light for their cigarette if they do not wish to take their medicine.

It is also difficult for women to resist medication; with so few resources in women's prisons, tranquillising drugs offer an easy alternative to serving a drug-free sentence. The resulting obesity and lethargy often increases a woman's dependency, a dependency that may never have been engendered outside the prison environment.

Epileptic Women in Prison

Women prisoners with epilepsy are particularly vulnerable and sufferers of Grand Mal epilepsy should not, we believe, be in custody at all. Certainly prisoners with epilepsy should not be contained in closed prisons where they will spend a considerable amount of time alone and without surveillance.

The case of Anna (surname witheld) reveals the dangerous attitude of prison medical staff to epileptics and although Prison Standing Orders state that these prisoners should be afforded extra protection, neither we, nor any of the ex-prisoners we have questioned, have ever known these orders to be carried out.

Mothers and Babies

A census on 15 March 1982 revealed that 719 women prisoners (out of a female population of 1,288) were mothers who had a total of 1,649 children, 209 of whom were aged three or under.

Incidentally, prisoners often do not know whether the medical officer they are seeing is a psychiatrist or a doctor.

SECTION FIVE: PRISONER OR PRISON: A QUESTION OF PRIORITIES

The Dutch phased out their full-time prison doctors for two reasons: the first, because they thought that the restricted sort of medicine practised by prison doctors led them to

becoming deficient; the second reason was that they thought full-time doctors, particularly those intimately involved with running the prison, became a little hazy about whether their main commitment was to the prison or the prisoners.

(Dr Richard Smith: "A Comparison of Five Health Services"

We believe that National Health Service doctors drawn from the community, unpaid and unmuzzled by the Home Office, and accountable only to the BMA, would not collude with certain prison practices and would better protect prisoners from abuse.

For example, a prison doctor has to find a prisoner "fit" for punishment, and that punishment can be extremely detrimental to that prisoner's health. Long periods of isolation in a strip cell is a case in point: Josie O'Dwyer spent a period of six months in isolation in Bleak House, Styal Prison (see "Criminal Women" edited by Dr Pat Carlen from which the following extracts are taken).

"The doctor in Styal should have seen that I was wasting away in body and in mind but all he did was to throw open the door, say "Fit?" and I wouldn't even answer him, I was so far away . . . I got worse and worse. I used to go off into spaces somewhere in my head to places where no-one else could ever reach me."

Dr Carlen comments:

"No-one intervened in Josie's situation until she was in such a state of debilitation that it was decided to transfer her to Pucklechurch . . at least Josie had received a temporary reprieve from the tortures of Bleak House. She was determined never to return there. She would die first."

Josie's words confirm this:

"I decided that I would go for the steering wheel and crash the car if they took me back to Styal."

Pauline Thomas also spent a four month period in Bleak House. Pauline told WIP that isolation turned her into "an utter zombie", and she described to Josie O'Dwyer how whilst in Bleak she had:

"gone to extremes—covered herself with semolina, gravy etc, just so that they would have to open the door and clean her up."

Another prisoner, Julie (name withheld), spent months in solitary confinement in Durham "H" Wing, and was considered fit for isolation even though she reacted to it by appalling acts of self-mutilation.

Doctors performing the function of finding prisoners "fit" are believed to be punitive for sanctioning such barbaric punishment and are held in contempt by many prisoners. We know of no cases where a prison doctor has found a girl or woman prisoner *unfit* for isolation.

"It is the privilege of the medical doctor . . . to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients."

(Declaration of Tokyo, 1975)

CI Wing Holloway Prison 1984–1985

A prison doctor may not know, and probably does not know what a prisoner is charged with, because that is purely a disciplinary matter; for example, on CI Wing, Holloway, between January and June 1984, 20 per cent of the women categorised by the prison as "highly disturbed" were punished for the offence of "absenting self without leave".

WIP informed Leon Brittan that:

51 per cent of the women on CI Unit were punished for such offences as offending against good order and absenting self without leave. We ask you to consider whether any

other unit for the mentally ill and distressed would punish patients for wandering off without first asking permission.

Not only did PMS doctors working on CI Wing not speak out about the terrible conditions and isolation these women were suffering, they also made them "fit" for *extra* punishment while they were there.

SUMMARY

Statement on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

"The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened."

(Article 3 Declaration of Tokyo 1975)

It is clear that PMS doctors are faced with a conflict in that the interests of the prison are not always in the best interests of their patients' health. However, in the light of this declaration, how can PMS doctors justify such practices as: sanctioning lengthy periods of isolation; working in conditions described by Larry Gostin (NCCL) as unfit for animals; suturing or giving permission to suture cuts without any form of anaesthetic; and condoning strip searches of pregnant and menstruating women by non-medical staff?

SECTION SIX: ACCOUNTABILITY

"Prison doctors should be able to speak out on the problems they encounter in prisons . . . yet when prison doctors do speak out they are either sacked or have their wrists slapped."

(Dr Richard Smith, British Medical Journal)

Deaths

The Home Office does not publish a list of prison deaths for public attention. It does inform the Press Association of deaths in custody, but the press is selective and many cases are never reported. Over 40 per cent of the women on CI Wing Holloway in June 1984 had no contacts of any kind outside the prison. This means, in effect, that girls and women can die in prison without anyone hearing about it until after the inquest, and only then if the case is of sufficient interest to warrant coverage.

As John Burton, the Fulham Coroner, pointed out about the inquest on Julie Potter:

"There was little interest in the press and you would have difficulty in getting sufficient information from the usual sources."

Other coroners are less forthcoming than John Burton; he is in fact the only coroner who has provided WIP with any information on a death in custody.

Doctors should surely welcome the most stringent inquiry into the death of any of their patients, but where we have been able to obtain information, this does not appear to be the case.

Drugs

PMS doctors work within a system that remains intransigently unaccountable even in the face of considerable public concern. For example, after much pressure the Home Office published figures on the amounts of drugs dispensed in prisons throughout the country. However, the figures they issue are meaningless and reveal nothing specific, because the Home Office does not define what strength a "dose" is, and also couples separate women's prisons together, ostensibly to protect the anonymity of the prescribing doctor. It is open to question whether the prisons selected are chosen arbitrarily, when one notes that Styal Prison is coupled with Cookham Wood; the former dispenses little or no medication to

prisoners (who sometimes have to wait twenty-four hours for a headache pill) whereas Cookham Wood is known to be a prison with a high rate of drugging.

The figures produced by the Home Office tell us very little and do not alleviate public concern. Doctors working within the PMS do not give clear information about their prescribing practices and so collude with this secrecy.

Channels of Complaint

Prisoners can petition the Home Office or complain to the Governor or the Board of Visitors about their medical treatment. However, petitions are often hard to obtain and the Home Office takes months even to make an acknowledgement; rarely is an answer forthcoming. The Governor and the Board of Visitors are not only medically unqualified to take up complaints, but the former is reluctant to intervene, while the latter, being hired and fired by the Home Office, are often considered partial and viewed with cynicism by prisoners, as agents of the prison authorities.

All prisoners' letters are subject to censorship, but if a prisoner writes to an outside contact (if she has any) complaining of medical treatment, the letter is vetted by the Senior Medical Officer and may be stopped altogether.

Official Secrets Act (Section 2)

The very worst aspect of the Prison Medical Service is that invisible doctors operate under conditions of complete secrecy. Prison doctors, unlike National Health Service doctors, are not accountable directly to the BMA but to the director of Prison Medical Services. Accountability then takes a political turn, as he is answerable to the director-general of the prison service, who is directly accountable to the Home Secretary.

WIP believes that, in 1985, it is wrong that teachers, priests, professional prison workers and personnel should not be permitted to speak about any aspect of their working life. It is far worse, and completely untenable, that prison doctors, whose job it is to treat and care for their prisoner-patients, should also be silenced in this way.

Conclusion

We believe that the preceding accounts of mistreatment and neglect of women prisoners provide the most convincing and powerful arguments for the abolition of the Prison Medical Service.

To summarise, we believe that those members of a caring profession responsible for the health and welfare of their patients should have no other consideration but their patients.

It is an indication of how far removed PMS doctors are from the rest of the world that they accept working in unsafe and filthy conditions, accept if not participate in brutal and degrading barbaric practices, accept drugging on a massive scale, accept without complaint that a proportion of their patients are wrongfully confined, and accept being silenced by their employers on all aspects of their work.

We believe because a high proportion of prisoners are sick, the general public is indifferent as to what goes on in prisons, the prisoner recipients of treatment are rarely believed when they complain and have few effective channels of complaint, the procedures of inquiry into cases of sickness and death are inadequate, that the Prison Medical Service has proved itself to be unethical, indifferent, uncaring and punitive.

WIP argues therefore that the Prison Medical Service is so bad that it should be totally abolished and replaced by normal NHS provision.

Memorandum submitted by PROP, RAP and INQUEST

SUMMARY

This memorandum is submitted jointly by PROP (the National Prisoners' Movement), RAP (Radical Alternatives to Prison) and INQUEST (an organisation concerned with deaths in custody and coroners' courts). It argues that the existence of the prison medical service in its present form creates a conflict between the loyalty of medical officers to the prison management and their duties to their patients. The use of drugs in prison, the general health care of prisoners, the prevention of suicides and the preparation of medical reports, are all affected by this fundamental structural flaw.

To resolve this conflict, the present duties of prison medical officers should be divided between two groups of doctors. Prisoners should have the right to choose a personal physician from among the GPs serving the area of the prison. The duty of advising prison management and the courts on medical matters should continue to be performed by doctors employed by the Home Office. The use of prison doctors to prepare medical reports for the courts should, however, be minimised.

In addition to their administrative duties, prison doctors could deal with minor ailments for which it would not be reasonable to expect the prisoner's own doctor to attend the prison. Their role would be roughly analogous to that of company doctors in industry.

1. The last official review of the prison medical service, the Gwynne Report of 1964, was undertaken at a time of great optimism about the future of prisons as treatment institutions. The Gwynne Committee believed that the prison medical service would be able to offer doctors an attractive, specialised career concerned with the treatment of offenders. The rehabilitative ethos also minimised the apparent conflict between the interests of the prisoner and those of the institution: the committee envisaged doctors and prison management working together as a "treatment team", helping the prisoner towards a good and useful life.

2. These assumptions are no longer tenable. Prison medicine is not a specialised branch of medical science, and few doctors would rate it highly as a career. Except in a handful of institutions, prison management no longer even pretends to be concerned primarily with rehabilitation; its aim is simply to keep the prison running as quietly and smoothly as possible. The conflicts which may arise between this goal and the medical interests of the prisoners have been most apparent in relation to the use of drugs, which is considered in some detail below. Critics within the medical profession have also pointed to the undermining of the confidential relationship between doctor and patient by the doctor's duty to prepare reports for parole, etc, and have questioned the ethics of certifying prisoners fit to be punished by methods which may be detrimental to their health. These points have been forcibly made by Dr P M A Bowden ("Ethical Aspects of the Role of Medical Officers in Prison", in *Medical Services for Prisoners*, Kings Fund Centre 1978), who concludes that it is not unethical:

> for a doctor to have divided loyalties so long as the patient appreciates the full implications of the situation and, importantly, that he also has the opportunity to be treated by a doctor who *does not* have such a dual role . . . it is surely the duty of a doctor in prison to make it clear that he is *not* acting as the patient's personal physician, and that what he learns of the patient may be used against his interests. The reality of the situation is that a prisoner does not have access to a personal physician during his term of imprisonment. (emphasis in original)

3. We contend that every prisoner should have access to a personal physician, who should be one of the general practitioners serving the locality of the prison (or, if the prison is near the prisoner's home as it should be, the prisoner's usual GP). Moreover, prisoners should enjoy the right enshrined in the National Health Service Act 1946, s.33(2), to choose the physician by whom one is to be attended. As a matter of principle, prisoners should enjoy all the rights of ordinary citizens except those which are lost as a necessary consequence of imprisonment, and the onus of proof should be on those who maintain that

the fact of imprisonment does necessarily entail the loss of such a right. Only when the right to choose their own doctor is recognised will prisoners be able to have confidence that they are not receiving an inferior standard of medical care.

4. The administrative functions of the prison medical service: writing reports, advising on hygiene, certifying prisoners fit for punishment, etc—would continue to be performed by doctors employed by the Home Office. These matters in fact occupy far more of the time of full-time medical officers than the medical care of individual prisoners. (Richard Smith, *Prison Health Care*, BMA 1984, p. 87). There is evidence (see below, paras 24 to 33) that some of these duties are performed in a perfunctory manner. Relieving medical officers of some of their responsibilities for prisoners' medical needs would leave them more time to perform them adequately. We would, however, wish to see a drastic reduction in the major part of many prison medical officers' workload, their role in preparing reports for the courts (below, para 34).

5. Prison doctors often have to deal with minor ailments which people outside prisons would deal with themselves (e.g. by taking aspirins or staying in bed) or for which they would attend the doctor's surgery rather than expecting a doctor to come to them. Such complaints could be dealt with, in the first instance, by prison medical staff but GPs with prisoner patients should hold regular surgeries inside the prison so that all patients who wished to see them could do so without undue delay. After all, what appears to a prison doctor to be a minor ailment may be something far more serious, as in the case of Ian Methven who was treated in Wandsworth for influenza when he in fact had severe bronchitis (INQUEST Annual Report, 1983–84).

6. The division of responsibilities which we propose would leave some very important decisions, such as the location of potentially suicidal prisoners, in the hands of prison medical officers. But the attendance of prisoners' own GPs at the prison would create (informally) a measure of independent scrutiny which is lacking at present, and a countervailing pressure on prison doctors to those of the institution. What the Prison Department, in its 1981 Annual Report, pointed to as the drawbacks of NHS care for prisoners—the lack of "central control" and the possibility of "competing priorities and conflicting advice"—we would see as the strengths of our proposals. Such a "dialectic" as Bowden calls it, is the only appropriate way to deal with a conflict of priorities which is inherent in the nature of prison medicine.

7. The remainder of this submission illustrates the effects of that conflict of priorities, of the "institutionalization" of prison doctors and their immunity from external scrutiny and accountability, on four major aspects of their work: the use of behaviour modifying drugs; the general standard of health care; the prevention of suicide; and the preparation of medical reports.

Drugs in Prison

8. The most notorious instance of the blurred dividing line between "care" and "control" in prison medicine is the use of behaviour modifying drugs.

9. Since the Prison Department began publishing figures on drug use in its Annual Report for 1979, RAP has published an annual table showing the dosage rate per prisoner in different establishments. Table 1, below, gives the dosage rates for 1982 and 1983, the latest available.

10. Every year, RAP has had to repeat the same criticisms of the misleading way the figures are presented. Although the Prison Department has made a slight improvement in its latest Report by stating the number of doses administered rather than the number dispensed (a small proportion of which are not used), the major deficiencies of the statistics remain:—

11. Firstly, the "broad classification" of the drugs as "psychotropic", "hypnotic" or "other" is practically meaningless without a more detailed explanation of which drugs are

in which category. It seems possible that the same drug could be described as psychotropic (sedative) or hypotic, depending upon the purpose for which it was given.

(Table 1) Table of Dosage Rates, 1982 and 1983

Position '82	Position '83	Establishment	Psychotropic drugs	Hypnotic drugs	Other CNS drugs	Total Dosage Rate 1983	Total Dosage Rate 1982
1	2	2 female closed prisons[1]	164	53	78	295	327
2	1	Holloway	144	39	64	247	365
3=	4	2 female borstals[2]	71	20	92	183	194
3=	8	Wakefield	114	15	54	183	119
5	6	Parkhurst	74	25	74	173	138
6	3	Brixton	115	12	36	163	201
7	5	2 female open prisons[3]	131	1	23	155	186
8	10	Wormwood Scrubs	77	9	44	130	108
9	7	Wandsworth	69	10	42	121	121
10	14	Winchester	44	3	61	108	67
11	13	Cardiff	19	1	55	75	79
12	11	Risley	37	10	23	70	97
13	9	Norwich	37	2	30	69	116
14	15	Birmingham	24	3	40	67	64
15	26	Dartmoor	12	4	49	65	17
16	12	Manchester	28	6	25	59	79
17=	17	Leeds	14	0	39	53	54
17=	16	Durham	18	3	32	53	61
19	21	Liverpool	19	4	26	49	41
20	19	Grendon Underwood	16	5	24	45	46
21	20	Bristol	23	3	16	42	45
22	18	Pentonville	20	2	17	39	50
22=	22	Ashford	25	4	10	39	39
24	25	Feltham	22	2	10	34	22
25	23	Leicester	13	1	13	27	37
26	24	Lincoln	14	1	9	24	33

[1] Cookham Wood & Styal
[2] Bullwood Hall & East Sutton Park
[3] Askham Grange & Drake Hall
(The 1982 figures also included Moor Court)
(CNS = Central Nervous System)

12. Secondly, the classification makes it impossible to distinguish between a relatively mild sedative like nitrezepan (Mogadon) and a dangerous, addictive barbiturate like amylobarbitone (Amytal).

13. Thirdly, the Prison Department has grouped together large numbers of prisons on the ground that medical services in these establishments are "largely provided by a single doctor" and "it is not considered appropriate to publish information about an individual doctor's prescribing practice". Thus the prisons concerned—including Gartree, whose controversial history of drug use we have already mentioned—are shielded from even this limited form of scrutiny. But the most serious distortion concerns the two women's prisons which between them have the highest dosage rate, Cookham Wood and Styal. The medical philosophy at Styal is known to be strongly *against* routine use of sedative or hypnotic drugs (this was confirmed in the 1982 television documentary *Living in Styal*, when a woman who asked for something to help her sleep was told: "You know what our attitude to that is in here."). Styal also has more than twice as many inmates (counting those in

Youth Custody) as Cookham Wood. To push the combined dosage rate of the two prisons to the top of the "league", Cookham Wood must be administering far more drugs than any other prison.

14. In 1982, a letter from Lord Belstead (then a Home Office Minister) to Lord Avebury gave details of the use of Depixol, Largactil and Chloral hydrate at Holloway, Cookham Wood, Parkhurst and Styal in 1980. These figures show that the Home Office can produce figures on specific drugs and specific prisons when it chooses, although they are based on the quantities of drugs *ordered* by each establishment (some of which are wasted because they have a limited shelf life), and the figures for Cookham Wood's use of Chloral hydrate are incomplete. Even this incomplete figure shows that Cookham Wood was using 10 times as much Chloral hydrate per prisoner than Styal (Table 2). The Prisons Inspectorate claimed in 1981 that the Medical Officer at Cookham Wood was "actively engaged in reducing the dependence of some inmates on night medication.

15. The fact that very large numbers of doses are prescribed, particularly in the women's prisons, does not in itself prove that drugs are being used for control, but there must be a suspicion that the institutional pressures on both staff and prisoners tend to promote the use of drugs.

(Table 2) Table of Drugs Ordered for Four Prisons, 1980

	Holloway (av pop 355)	Cookham Wood (av pop 63)	Parkhurst (av pop 262)	Styal (av pop 244)
LARGACTIL				
Ampoules	800	Nil	Nil	5
Conc Solution 13.3 per cent	Nil	Nil	4 litres	Nil
Forte suspension (100mg in 5 mils)	8.1 litres	1 litre	Nil	Nil
Syrup (25mg in 5 mils)	318 litres	500 mils	2 litres	105 litres
Tablets: 10mg	1000	Nil	Nil	Nil
25mg	50	50	Nil	50
50mg	50	Nil	Nil	Nil
100mg	450	Nil	50	100
Total per prisoner	5.2g	0.4g	2.1g	2.2g
DEPIXOL				
Ampoules 20mg	80	30	10	30
40mg	130	5	10	50
100mg	50	5	Nil	Nil
Total per prisoner	33mg	21mg	2mg	11mg
CHLORAL HYDRATE	30 kilos	15 kilos	6 kilos	2.2 kilos
Total per prisoner	85g	238g	23g	9g

That is, doctors may prescribe tranquillisers, etc, in order to achieve a "quiet life", and prisoners may fear formal or informal sanctions if they do not consent to being kept quiet in this way. Or they may accept drugs as the only way to cope with the stresses of imprisonment in the absence of any more constructive help.

16. It may, indeed, be a considerable hardship for a prisoner who has been regularly prescribed drugs to help him or her to "cope" to be suddenly deprived of them. This was illustrated by many reports which reached PROP after the former Medical Officer at Gartree, who was notorious for his liberal use of drugs, was succeeded by another doctor who would advise prisoners hoping for a sedative that they would do better with a good work-out in the gym. There may be something to be said for each of these approaches, but a sentence of imprisonment should not entail being sentenced to a particular medical

philosophy. The fact that Wandsworth prescribes five times as many drugs per prisoner as Lincoln, although both are overcrowded local prisons for men, gives some indication of the variation in prescribing practice among prison doctors.

17. The fact that there are more constructive methods than drugging to help even the most disturbed prisoners to cope with their situation is illustrated by the consistently low position in our tables of the two specialised psychiatric establishments, Grendon Underwood and Feltham. It is not the presence of mentally disturbed prisoners *per se* that is associated with a high use of drugs, but the attempt to contain them in an inappropriate environment.

18. The strongest evidence of the use of drugs to control prisoners comes from the mouths and pens of prison doctors themselves. Dr Prewer, the Senior Medical Officer at Parkhurst, predicted in 1974 that "medicine in its wider sense is going to play a larger and larger part in both the treatment and control of those offenders who come into penal institutions", adding that "treatment and control are essentially two sides of the same coin" (*Causes for Concern*), ed Scratton & Gordon, 1984). His colleague at Albany, Dr C H McCleery, gave an illustration of what this meant in a 1977 article in the (then restricted) *Prison Medical Journal* on "Treatment of Psychopaths with Depixol". The prisoners he had treated in this way were, he wrote, "regarded purely as Albany discipline failures" and "showed no evidence of formal mental illness as such". Another "discipline failure" was George Wilkinson, who died on hunger strike in Liverpool Prison in 1979. At his inquest Dr Harold Eldridge, who had prescribed large quantities of drugs to Wilkinson when he was in Wandsworth, explained that he:

> tried to co-operate with the governor to uphold discipline and control over people like Wilkinson and to use medication where we think there is a medical indication—and I may say it is extremely difficult to weigh the balance between discipline and medical control.

Standards and Scrutiny

19. There is probably as great a range of medical attitudes and abilities to be found in the prison medical service as there is in general practice. Some of the doctors George Wilkinson encountered on his Odyssey through the prison system treated him with great humanity; others with sheer callousness. The crucial difference between prison medicine and general practice is the absence from prisons of the safeguards that protect patients against bad GPs, the right to choose another doctor, and the system of accountability through Family Practitioner Committees, Community Health Councils etc. The two recent inquests where prisoners have been found to have died from "natural causes aggravated by lack of care", and the many other cases in INQUEST's files where serious doubts have been raised about the medical care the prisoner received, may not be sufficient to support a generalised indictment of all prison doctors, but they can hardly be reassuring for the prisoners who are stuck with the particular doctors concerned.

20. The point we are making—that the structure of the prison medical service leads to a tolerance of bad doctoring—is one that has been strongly voiced within the medical profession. In his book *Prison Health Care*, Dr Richard Smith argues that

> the rigid Home Office hierarchy will discourage (doctors) from putting their patients' interests first but will not exert much pressure to maintain medical competence. Rather the hierarchy will encourage them to pursue its primary aims, which are to keep prisoners inside the prisons and run them with the minimum "fuss" and as cheaply as possible.

An editorial (which we understand was prompted by a very senior member of the BMA) in the magazine *World Medicine* (30 October 1982), claimed that privately:

> The medical profession's elected and appointed representatives . . . admit dismay, deep dismay. They acknowledge that, while there are dedicated prison doctors, the system is one which enables bad doctors, incompetent and maybe worse, to practice without the controls or scrutiny to which ordinary GPs are properly subject . . . The prisoner without

choice of doctor is bound to lose his other medical rights too: the right to refuse treatment, the right, or at least the opportunity, to regulate his own intake, which is always important and, with major tranquillisers, vital.

And in a "Personal Paper" on his resignation as medical adviser to the Inspectorate of Prisons, (*The Lancet*, 4 June 1983) Dr Benjamin Lee wrote;

Prisons varied from those in which a local part-time GP gave a dedicated service . . . to others where the doctor had, equally clearly, run out of sufficient stamina even to remain on the ethical qui vive which must, as in industry, be constantly maintained if the doctor is not to function merely as a rubber stamp on behalf of management . . . What is clearly essential is that prison doctors must be independent from, and not identified with, management.

21. Dr Lee's resignation also points up the inadequacy of the Inspectorate as a form of independent scrutiny of the prison medical service: "the medical findings during the inspection had to be filtered through and translated by, the lay "team leader" ", a seconded prison governor, who could accept or reject them "in the light of somewhat inconsistent and expedient criteria". The Inspectorate's reports have, in general, been conspicuously uncritical on medical matters.

22. All three of the organisations submitting this memorandum have published accounts of cases where prisoners have received inadequate or inappropriate medical treatment. We shall not include details of these here, both for reasons of space and because we realise that select committees do not normally investigate individual cases. We would, however, draw the attention of the committee to the very disturbing testimony of women ex-prisoners, contained in the submission by Women in Prison.

The Role of Prison Doctors in Suicide Prevention

23. The Chief Inspector of Prisons' report on Suicides in Prison, published last year emphasises the central role of prison doctors in suicide prevention. The Inspectorate's recommendations ignore the evidence that the institutional pressures on prison doctors militates against successful performance of this role. The report itself cites an article from the Prison Service Journal which draws attention to "the institutional forces which perpetuate the myth that prisoners can cope with anything . . . the doctor who shows understanding and concern can all too easily be labelled as "soft" by other members of staff".

The Governors' Branch of the SCPS in their evidence to the Inspectorate commented:

It appears to us that there is too much emphasis on the role and decision of the Prison Service Medical staff in this area . . . It may well be that some lay people are equally adept at recognising signs of depression and may be unencumbered by the need to recognise and reduce malingering which, quite properly, influences medical officers. (para 2.11)

24. An example of the kind of attitude which does nothing to help prevent suicides was given at the inquest on William O'Neill, the latest in a long line of suicides at Brixton Prison. According to his cellmate, O'Neill had told the doctor he was considering suicide. The doctor's response was "People who say that never do it." Even more disturbing are the repeated reports from women's prisons of self-inflicted injuries being stitched up without anaesthetic. Prison doctors often fail to note indications that prisoners have suicidal tendencies. In a study of prisoners in Brixton (where there were five suicides in 1984), researchers from the Institute of Psychiatry found, by interviewing the prisoners, that 71 (out of 203) had a history of suicide attempts; but in only 33 cases was this fact recorded in their notes (Smith, *Prison Health Care*, p. 100). Part of the problem lies in the superficiality of their contact with the prisoners. In the case of Joseph Dean, who died from "suicide due to lack of care" in Wandsworth, the prison doctor had not noticed the scars on Dean's wrists when he examined him on reception. He explained that there was only a limited amount of time to examine each prisoner, and the doctor had to rely largely on what the prisoner told him. At the other inquest where a "lack of care" verdict was recorded on a

prison suicide, that of James Heather-Hayes in 1982, the doctor gave the following description of his examination to determine whether the prisoner was fit for punishment:

> I go into a cell and I say "Good morning, are you alright?" and I wait for an answer. Most say nothing; Heather-Hayes said nothing. If I saw signs of mental illness or silence or abusive behaviour, I place on the cards "temporarily unfit for adjudication". In the case of Heather-Hayes I saw no signs, so I passed him fit for adjudication . . . (Excerpt from the official transcript. "Nothing" should probably read "that nothing is wrong".)

This procedure, in the case of a prisoner who was clearly disturbed, took "one minute". To call it a "medical examination" would be a misuse of language.

26. If the explanation of these shortcomings is that prison medical officers are overburdened with work, then relieving them of part of their responsibility for the medical care of prisoners should ease the problem. A sympathetic outside GP could also make an important contribution to suicide prevention by enabling prisoners to discuss their problems with someone independent of prison management.

Medical Reports

27. One of the reasons behind the high suicide rate at Brixton, and the appalling incidence of self-injury in Holloway, is the number of prisoners who are remanded and kept in wholly unsuitable conditions, for medical reports.

28. The Home Affairs Committee, in its report on *Remands in Custody* (1983–84 HC 252), accepted that while some "seriously disturbed persons have to be treated in this way for their own protection and that of the community" (and we would question whether in such cases prison is really the appropriate place), "in most other cases people could perfectly well be kept under supervision in their own home or in a hostel, and that diagnosis in psychiatric cases could be distorted by imprisonment". (para 51).

29. There is some evidence that what distorts diagnosis is not only the effect of imprisonment on the prisoner but also its effect on the doctor. Gibbens, Soothill and Pope, *Medical Remands in the Criminal Court* (Oxford 1977), state:

> The opinions of medical officers are probably more heavily influenced by the social and professional setting in which they work than they believe. All of the recommendations for treatment in prison and for 16 out of 17 institutional sentences were made by prison doctors. Of the recommendations for a supportive environment (hostels, sheltered communities, etc) 71 per cent came from a hospital, ie community based psychiatrist. (p 68).

30. Further evidence comes from research by Dr D Treves-Brown ("Criteria for Admission to Special Hospitals" *Prison Medical Journal*, Jan 1976) He points out that, under what is now s37 of the Mental Health Act 1983, it is the prison doctor who calls in the second doctor whose opinion is required before the court can make a hospital order. As a result, "If the Prison Doctor thinks a patient should be in Broadmoor there is virtually no way of preventing this recommendation taking effect." He also found that "Mental State . . . was not a significant criterion for admission to a Special Hospital. It is much more likely . . . that the Mental State was used to support or justify a decision made primarily on other grounds." Treves- Brown does not elaborate on these "other grounds", but they could well include the doctor's assessment of how manageable the offender would be in prison.

31. If this is true of medical reports it probably applies even more strongly to transfers of sentenced prisoners to special hospitals. Many prisoners believe that being "nutted off" to a special hospital is one of the penalties faced by trouble-makers. Allegations of this kind are hard to substantiate, but something clearly went wrong in the case of Steve Thompson who was transferred from Gartree to Rampton in December 1980, just five days before the end of his sentence. One of the two doctors who sanctioned his transfer under s72 of the Mental Health Act 1959, on the ground that he was schizophrenic, later stated that he had been misled by Home Office allegations, denied by Thompson, of violent behaviour. Two of

Rampton's own consultant psychiatrists reported that Thompson was neither mentally ill nor dangerous and he was discharged by the Home Secretary after a public and parliamentary campaign.

32. On the other hand, prison doctors may fail to diagnose mental illness in a remand prisoner because they base their report solely on his/her behaviour in prison. This happened in the case of Paul Worrell who died in Brixton Prison in 1982. His behaviour prior to and including the offence of which he was convicted showed clear signs of mental illness but the prison doctors could not find the time to interview his family and initially reported that he was well. After he was remanded a second time a consultant psychiatrist diagnosed schizophrenia and made an offer of a hospital bed which was later withdrawn. A hospital order was made but Paul remained in prison because no hospital place had been found. Altogether he spent over four months in Brixton before he was found hanged in his cell (the inquest returned an open verdict).

33. Magistrates may have an unrealistic idea of the diagnostic facilities prisons can provide. (Gibbens et al (*op cit*, p 93) write:

> Many magistrates believe that "daily observation" in custody will lead to a more thorough and reliable assessment. This would be true of psychotic or more grossly disordered offenders, but the great majority of the less obviously disturbed are kept in ordinary cells until called for an interview for an hour or less, similar to that provided by a Health Service consultant.

Other reasons they suggest may lead to a custodial remand are administrative convenience; the forensic experience of the prison medical service; and, disturbingly, the desire to give offenders a "taste of prison". In short, the existence of the prison medical service both encourages remands in custody, and makes it more likely that those remanded in custody will receive an institutional disposal.

34. As NACRO has recently pointed out (*Bail and Remand in Custody*, 1985) there appears to be no shortage of psychiatrists willing to assess people on bail, and the provision in the Bail Act 1976 under which bail can be refused solely because it would otherwise be "impractical" to obtain a report should be repealed. If appropriate use is also made of the power to remand to hospital (Mental Health Act 1983 s35), and of regional secure units, it should be possible greatly to reduce the number of medical reports prepared in prison, and those who are remanded in custody should if possible be examined by an outside psychiatrist. Recommendations for a hospital order or the transfer of a sentenced prisoner to hospital should be signed by two doctors other than the prison medical officer.

Examination of Witnesses

Ms Chris Tchaikovsky and Ms Helen Moore, Women in Prison; Mr Tony Ward, RAP/INQUEST, and Mr David Leadbetter, INQUEST, called in and examined.

Chairman

483. Good afternoon. Can I thank you, first of all, for sending us your documentation and for agreeing to come and answer our questions. We are grateful to you. Can I start off by asking you if you could tell us something briefly about the organisations that you represent. Perhaps, Mr Ward, you might like to start off with RAP, would you, and Mr Leadbetter could answer about INQUEST?

*(*Mr *Ward.)* Very briefly, RAP is a pressure group which was established in 1970. It is concerned with penal policy generally, not just prisons and not just alternatives to prison. We have taken a particular interest in the Prison Medical Service, particularly during the late 1970s and early 1980s when we were involved with PROP as well in a body called Medical Committee Against the Abuse of Prisoners by Drugging.

[Chairman *Contd.*]

484. Thank you. Mr Leadbetter?

*(*Mr *Leadbetter.)* INQUEST has been going now for some four years—or in fact five years, I think. We were funded from late in 1981 by the GLC, to look at police-related deaths in London, but we regard our remit as somewhat wider than that. We are concerned and interested in prison deaths also. Occasionally we branch out from that to deal with special hospitals and even on occasion, mental hospitals. However, our main remit has been in London and taking care not to spend London's money outside.

485. So you are mainly involved with what goes on in the Greater London area?

*(*Mr *Leadbetter.)* Yes, although we have volunteers in other parts of the country, and we do attempt to cover prison deaths wherever they happen.

Mr Lewis

486. Do you go into voluntary liquidation at the end of next month?

*(*Mr *Leadbetter.)* That is what we are waiting to see.

Chairman

487. Ms Tchaikovsky?

*(*Ms *Tchaikovsky.)* We were set up in March 1983. The central aim of our organisation is to free prisons from the direct and secret control by the Home Office, that includes the Prison Medical Service, and to bring to light the appalling conditions in prisons, to let the public know who are in our prisons, and to campaign for change, particularly to change the complete and secret control of the Home Office over prisons.

488. Thank you very much. Do any of you have any indication that there has been any difficulty from the Home Office, in the way in which you operate? Have you had any obstacles put in the way in which you operate, by the Home Office, or have you been quite free to campaign as you wish, to visit when you wish and so on?

*(*Ms *Tchaikovsky.)* We certainly have not been able to visit as a group. Then again, though, we are an ex-prisoner group, so for that reason, although we visit prisons and we have now established a dialogue with prison governors which we are very pleased about, we certainly were not given permission by the Home Office to visit prisons as a group. However, I think that is more to do with our ex-prisoner status and our campaign status as a group, to be fair.

*(*Mr *Ward.)* I think we are concerned, as a general issue, with the secrecy surrounding prisons, the Official Secrets Act and so forth. One of the particular points we are making in the submission is to do with the quality of the information that the Home Office makes available in its statistics on drugs. But we have not had any particular obstruction as an organisation, in recent years anyway.

Mr Lewis

489. Ms Tchaikovsky, from what you say, if you want to go to a prison you go to see the governor, and you do not get any clearance from the Home Office?

*(*Ms *Tchaikovsky.)* No, we do not. I think the Home Office are now aware that we are visiting governors. Also we visit prisoners, but we visit in the regular visiting rooms, in the normal way. I would not say the Home Office have been obstructive, but there is a point to make here. The Home Office cannot be obstructive, but we have had an awful lot of misinformation or even disinformation. As we have put in our submission, if you look at the supposed information they put out about drugs, for example, when they give you numbers they give figures on doses of drugs, but they do not qualify what a dose is. I would say that that was misinformation or disinformation.

490. Yes, but the Home Office could instruct a governor not to instruct you, could they not?

*(*Ms *Tchaikovsky.)* Indeed yes.

491. Do they?

*(*Ms *Tchaikovsky.)* No.

Chairman

492. Mr Leadbetter, did you wish to answer the previous question?

*(*Mr *Leadbetter.)* Yes. We have not had any obstruction, but in our ordinary function of going to inquests concerned with prisoners' deaths, whether that be in a police station or in a prison, we face this great problem of lack of disclosure, where all the documents that one would have, were it a trial, are held by the other side, and counsel representing the family do not get to see them. That is a great problem. Also nobody's family gets legal aid for representation at an inquest. This is a thing we have long campaigned for. But the Home Office, of course, are legally aided by

[Chairman *Contd.*]

the rest of us, in that they always have paid counsel at inquests. So there is that loading in the system, but we have not had specific obstruction.

493. In *your* submission—Women in Prison—you say that the case histories that you have sent are not just isolated ones; that you have got much evidence about the problems faced by women prisoners. The submissions do make quite serious allegations against prison medical officers. Can you tell the Committee how you check the allegations that are made in the submissions that you receive?

*(*Ms *Tchaikovsky.)* Yes. I did say in the letter to you that we were predisposed to believe prisoner evidence, and that always disbelieving the recipients of the treatment is probably the charge most often brought against the Prison Medical Service. I think that is very important. You have got to listen to the recipients. We have tried to get information. We approached the coroner in the case of Julie Potter, and John Burton actually gave us information on the death of Julie Potter, which was a great help. We have telephoned the Home Office to give us more information about specific cases, but unless we have the name of the person—we might just have the name Ann or Susie or Stevie—unless we give them the full name or the date of an incident, they will not give us information. We do try to get around that by using the press and media, they can call and the Home Office are more helpful there.

494. It is not unreasonable to ask for the full name and the date, is it?

*(*Ms *Tchaikovsky.)* No, it is not unreasonable, but I think the onus is on them. They are running a closed and secret system. We want to get information. We need to get information. As I put in the submission, a woman can die in the prison, and if she has no family and friends outside, and if the press and media do not pick up on it, no one will know. I that that is unacceptable. I think the onus is on them to be as open as possible in their dealings with institutions. They are all subject to the Official Secrets Act.

495. Have you talked to prison doctors or prison governors about the cases you took up?

*(*Ms *Tchaikovsky.)* Yes.

496. How do they respond to you?

*(*Ms *Tchaikovsky.)* There is always the problem of on the record talking and off the record talking. Prison governors have to have clearance with the Home Office before they speak to anyone; well, not anyone, but anyone who they know campaigns. We have numerous discussions on the record and numerous discussions off the record. We have spoken to one ex-PMS doctor, who I think has sent a submission to you. I think it is interesting in that one PMS doctor has chosen to speak out. We have not had any more information from prison doctors. We are following a case through a doctor in Broadmoor who is more inclined to give us information. We attempt to substantiate those cases where we can, and will. A lot of these things we knew of first hand. I knew of cases that were dreadful because when I was in prison myself I saw them—and Helen the same—and we are actually predisposed to believe these women because we know the workings of the PMS and the standard of medical care.

497. Did you talk to doctors or governors at the time?

*(*Ms *Tchaikovsky.)* I have talked to governors about most of the cases, and certainly two governors whose prisons are mentioned in the submission have seen the submission.

498. What response did you get from them? I am talking about cases you say you witnessed yourself.

*(*Ms *Tchaikovsky.)* This is a long time ago. I did not witness any of these cases. I have witnessed a case where a woman miscarried her baby into a bucket in the middle of the morning. I was in prison when Patricia Cummings died from fire, a case similar to Julie Potter. One governor said off the record, "Fair comment", another said she felt we should have put the view of prison officers. I think there is some sense in that. If we could speak to prison officers we would put their views. We are getting to a position where the POA have notified us for informal discussions. We could have put more of the officers' side of things. For example, in the Julie Potter allegations of delay on that case she said we could have put that the officers are very frightened to go into the cell of a woman on fire. I accept that.

499. Do you wish to add anything to that?

*(*Ms *Moore.)* Not at the moment.

[Chairman *Contd.*]

500. When people come to you with these rather serious allegations, if they are either former prisoners or relatives of prisoners, to take their case, do you encourage people to take their case to the courts?

*(*Ms *Tchaikovsky.)* No, I do not. PMS are litigious and have won every case. An ex-prisoner's word is very rarely taken to mean anything. I would not advise it.

*(*Ms *Moore.)* The decision is usually left to the family, not only because of the previous experience of cases never being won by anyone other than the PMS, but also because of the stress on the family by that kind of case.

501. Any case of any sort brings stress on the family. If you want justice you have to be prepared to do that.

*(*Ms *Tchaikovsky.)* I believe Angela White put a submission in and is pursuing a case. There is the family of Mark Sancter—and his more recent death—who are suing for neglect, and Ruth Dyson, who are taking the Home Office to court for neglect. It is happening. I do not think we are qualified; we are campaigners and not legal people.

502. We are only seeking to get information from you. You make complaints and we want to know how far the complaints are taken and with what result. Where you know cases have been taken how did the verdict go?

*(*Ms *Tchaikovsky.)* They are just being pursued at the minute.

503. You do not know of any cases that have been taken in the past against governors?

*(*Ms *Tchaikovsky.)* No.

504. Or prison officers?

*(*Ms *Tchaikovsky.)* Not personally.

*(*Mr *Ward.)* Yes, there have been some cases. There was the case of John Freeman who sued the Home Office unsuccessfully for alleged drugging without consent. There is another case which I do not know the name of, mentioned in the chapter by Dr Whitehead, which I think is appended to the Prison Reform Trust's submission, in which a prisoner did successfully sue the Home Office for forcible injection.

505. What happened?

*(*Mr *Ward.)* He was awarded damages against the Home Office.

*(*Mr *Leadbetter.)* INQUEST is primarily concerned with the inquest and, yes, we would in appropriate cases encourage people to go on to court, after the inquest.

506. Do they?

*(*Mr *Leadbetter.)* Yes, quite frequently. One always respects the wishes of the family. In fact, it is a very difficult problem, if I can say, where someone has no family, or where the family is estranged from them. Although coroners have a discretion in such cases they rarely exercise it in favour of anybody else other than family. A lot of cases which should be thoroughly investigated are not. Normally we get a coroner who will not allow it.

507. If there is a death there is always an inquest?

*(*Mr *Leadbetter.)* Yes, but there are inquests and inquests.

*(*Mr *Ward.)* There is one qualification to that which is that the law requires an inquest on death in prison but it is not clear whether it requires an inquest on death in a remand centre or youth custody centre.

508. Any death requires an inquest?

*(*Mr *Ward.)* Any sudden or unnatural death or in prison. If there is a natural death which occurs in a penal establishment, not necessarily a prison, the law does not, strictly speaking, require an inquest. The Home Office, in a circular to coroners, advise them that they should have an inquest in those circumstances. There are some cases where the coroner does not, and does not hold an inquiry. We spoke to someone in the Home Office about that; I think they said that in 1982 there were five such cases.

*(*Mr *Leadbetter.)* These were cases of people who had been taken from hospital to prison. The Act does not say "custody", it says "prison". It does not matter how many warders there are clonking about in great big boots up and down the ward, you do not necessarily have an inquest with a jury if the coroner decides otherwise, whereas you would have done if, a couple of hours before, you had been in prison and died there.

Mr Lewis

509. In reply to the Chairman you said you are a campaigning organisation, and also in reply to the Chairman you suggested, or hinted, that so far up to date you have not had any success?

[Mr Lewis *Contd.*]

*(*Ms *Tchaikovsky.)* We are initiating the C1 campaign in Holloway at the moment; we are hoping for success from this and hoping you will find the PMS unreasonable.

510. Do you think that the powers that be look upon your organisation as people with a grudge?

*(*Ms *Tchaikovsky.)* Possibly a grudge in people, yes.

511. Would we be correct in assuming that?

*(*Ms *Tchaikovsky.)* I think that is fair comment. I think that is possibly true.

512. Arising out of your period inside?

*(*Ms *Tchaikovsky.)* I think prison can breed a terrible feeling of injustice and a grudge in people.

Sir David Price

513. Could we go to the central recommendation of three of the four organisations represented here, RAP, PROP and INQUEST. When you distinguish between two separate functions in the existing Prison Medical Service and you suggest that the administration, advice to prison management and to the courts should be carried out by doctors employed by the Home Office, presumably "employed" means also paid for, and you have quite a lot of consultant psychiatrists coming in who cannot be said to be employed, but that on the other hand prisoners should be able to choose a GP of their own choice, that is a fair description, is it not, of your central theme?

*(*Mr *Ward.)* Yes.

514. With regard to the latter, is this not very far off the present practice in a number of prisons where they have not got permanent prison medical officers, where a GP has to come in part-time to fulfil very much that role?

*(*Mr *Ward.)* Where there is a large prison with more than one part-time GP, it would seem to be practical to give the prisoner a choice of which part-time GP to be seen by, but I do not think that right is recognised at present.

515. The point I am trying to get is just a stage up the road before what you have replied. Do you find that prisoners are more satisfied with the GP who comes in from outside, than they are with the permanent prison medical officer?

*(*Ms *Tchaikovsky.)* Dr Kilgour, I am sure, made it clear to you that when GPs work in a prison they are in fact under his direct control, they are working for *him*, they are not independent National Health Service doctors. They are then engaged by the Home Office to carry out that task. If you have taken the evidence of Dr Conran from Pucklechurch Prison, I think he made it quite clear that even a GP who has a normal surgery, a normalised environment outside, can find prison brutalises—or now brutalises but narrows—his medical parameters. I think he would put it better than I do. But I think we must be clear that GPs working in prisons are not GPs just walking in from the outside and setting up surgeries in prisons, they are at that point both under the Official Secrets Act and subject to the control of Dr Kilgour and the Prison Medical Service.

516. Yes, but the prison has got to provide surgery facilities. Otherwise the implication of what you are saying is that every prisoner should have the right to go to an outside NHS surgery.

*(*Ms *Tchaikovsky.)* No, I am saying that GPs should have a right to be able to work freely, unhampered, in a prison.

517. What evidence have you got that the clinical freedom of a part-timer is restricted?

*(*Ms *Tchaikovsky.)* For example, again quoting from Dr Conran (who I believe has written to you), the keeping of flimsies, the medical records. He found that they were kept in pencil, they were actually written in pencil, and when the treatment of a prisoner was changed they were rubbed out and they were re-entered. He took steps to stop this dangerous practice, as he believed it to be, and found quite a lot of difficulty in the prison in doing that, and a lot of hostility to the changes he wanted to make. So that would be one example of how a doctor's freedom would be impinged within the rather bad system that is operative at the moment.

Chairman

518. Then what would you wish general practitioners to do? Could you let us know what changes you would like to see?

*(*Ms *Tchaikovsky.)* They go into elderly people's homes, they go into other institutions in the community, free and unhampered by any constraints.

[Chairman *Contd.*]

519. Which GPs are you suggesting? Yesterday we went to a large men's prison where the entire service is delivered by a local general practitioner. You are not suggesting that every prisoner should be able to bring his *own* general practitioner in, are you?

*(*Ms *Tchaikovsky.)* No. I think that would be impracticable.

520. What do you suggest?

*(*Ms *Tchaikovsky.)* I suggest that doctors who are working in prisons are directly accountable to the GMC and the BMA.

521. As far as we know, they are.

*(*Ms *Tchaikovsky.)* In no way. Dr Kilgour has not said that. He has said they are accountable to him, and he in turn is accountable to the Home Secretary.

Sir David Price

522. I think you are being a little unfair. In terms of medical ethics they are responsible to the medical profession, and ultimately, I suppose to——

*(*Ms *Tchaikovsky.)* —to the BMA.

523. A GP could be hauled before the General Medical Council if he had acted unethically, could he not?

*(*Ms *Tchaikovsky.)* He could. Would you mind if we take that further? We have talked in our submissions about the ethics of finding prisoners fit for punishment. How can you possibly have a doctor/patient relationship where that doctor actually finds the prisoner fit for lengthy periods of isolation which are damaging to that patient's health? That is where the breach of ethics comes in. That is where, rightly or wrongly, I believe that the Home Office should not contol doctors in the Prison Service. I do not think they should be sanctioned by the BMA, and we are very sad that the BMA wish to continue to sanction the Prison Service.

Mr Kennedy

524. I recognise the dilemma that you are pointing at. If you have that clash between medical ethics and the administration of justice, to put it in the broadest terms, what do you then have as a medical input, which presumably you recognise as necessary in some shape or form?

*(*Ms *Tchaikovsky.)* I think our country compares very unfavourably with other countries. I think that necessity is taking it too far. Yes, punishment and sanctions are needed, but the sanctions that are given in this country are obscene for the most part; they far outweigh the control problems that prisoners create. The control problems that are presented by prisoners are, for the most part, because of POA restrictive practices, being locked up all the time. We have no facilities. We have punishment which keeps that element of control. I do see that there would be a conflict for National Health Service doctors working in it, but I think that that would thrash out that conflict. If there were an open medical service, if the National Health Service were in prisons, I think that those conflicts could be thrashed out, could be resolved, and prisoners would end up getting far less punishment.

Sir David Price

525. Have you, on this specific point, got any evidence from Scotland?

*(*Ms *Tchaikovsky.)* No, none.

526. You know there that the medical support for the prisoners comes through the NHS?

*(*Ms *Tchaikovsky.)* That is right, yes, and apparently it works very well. In Ireland too, as I understand it, it works very well. I must say, structural problems are rather proscriptive, and I am not really as up on that as I could be. I do not know how it should work.

*(*Mr *Ward.)* It is unfortunate that the representative from PROP cannot be here. I believe his view is that the Scottish arrangement is not that much better; and that the mere fact of the medical services being provided by part-timers does not solve the problem. What we are arguing essentially is that to avoid the ethical conflicts and what might be termed the institutionalisation of doctors there should be a division between those doctors who provide the personal medical services to prisoners and those doctors who provide services to the Home Office and to the prison authorities. We also think that it ought to be practical, in many, if not all, prisons, to give prisoners a choice of more than one doctor to act as their personal physician.

527. Do you think this division of responsibility, which you propose, would really make prisoners trust the doctor who is giving them medical attention more than under the present regime? It might initially,

[Sir David Price *Contd.*]

but surely the real thing is the fact that the person is in prison in the first place?

*(*Mr *Ward.)* I would have thought, certainly from the ex-prisoners that I have talked to, that it would make a big difference if they knew that the doctor they would be dealing with was simply their doctor and was not a doctor who was also writing reports on them, advising the prison, who might be called upon, as Ms Tchaikovsky said, to say whether they were fit or unfit for punishment and so forth. If I could also turn back to the accountability problem, what we were talking about was not so much accountabilities to the BMA, of professional ethics; it is the lack of accountability through the channels of the community health council, the family practitioner committee, that would be available outside, which are not available inside the prison.

528. But how far have you thought through what it would mean in practice? Take the example of GPs taking on, let us say, a large Part 3 home of a local authority. They tend to be the same GPs. It is also often shared out within a group practice, and the partners share the duties, so that there is given complete coverage to, let us say, a home with 60 or 70 elderly people in it, but the same doctor is not doing it all the time. Indeed, one of the great arguments is that you are getting broader experience and bringing it to bear on the specific problem, in this case, of elderly people. Surely this is what you would require, would you not, in prison? Therefore, inevitably the number of doctors visiting would be limited. An arrangement would have to be worked out between the prison and a group practice or two group practices, to give the coverage that is necessary, because to give proper medical coverage it has got to be 24-hour coverage, has it not?

*(*Mr *Ward.)* Yes. There could not be an unlimited number of doctors, but there could be enough doctors to enable the prisoner to have a choice. That is not to say that every time a prisoner has 'flu or some minor ailment he or she can automatically have the doctor of his or her choice; but at least that they would then be seen by the doctor who was available at the time, and they would have an opportunity later to see the doctor that *they* would choose to see.

Mr Galley

529. There is a point about the availability of medical services; as things stand on evidence from many prisons, medical advice is more readily available to somebody in prison than somebody outside. If you have your system would that advantage be lost?

*(*Ms *Moore.)* I do not think that exists.

*(*Ms *Tchaikovsky.)* A lot of prisoners' requests to see doctors are vetted. A lot of prisoners' claims that they are ill are assumed to be malingering. I find that an extraordinary thing to say. As you know, I think it was Dr Richard Smith who said this that if you want to see a doctor it is because you want to go on the centre and because you want to pass a message and get out of your cell. There are all those reasons but, in fact, you might want to see a doctor but you have to get through that obstacle course of disbelief. I would find that untrue. It is not like getting on a bus to go to the surgery.

*(*Ms *Moore.)* When receiving medication you are not told what you are receiving in prison.

*(*Mr *Leadbetter.)* We do not seem to have any problem when it comes to organisations such as universities. There, obviously, one does not have the GP one had outside if one lives in Fort William and goes to university in Glasgow.

Mr Kennedy

530. You have been doing your homework!

*(*Mr *Leadbetter.)* Anyone who has been in that situation will bear me out, that the students would try and distinguish between an officially appointed doctor and other GPs who they could have as alternatives to register with. With the latter they felt that these doctors were their doctors; they were on their side; they would perform a service for them. There was always this ambiguity about university doctors, however good they were. It is not a perfect analogy, but I do not see why the list of GPs in the locality, who are available for this service, should not be made available to prisoners so that they could have some element of choice. No-one in the community outside has a total choice.

*(*Mr *Ward.)* The analogy with company doctors in industries—there might be a doctor who was an administrative medical officer who was also available to deal with minor medical ailments, but also prisoners' personal doctors who were drawn from the practices surrounding a prison.

Mr Lewis

531. What about reports made by psy-

[Mr Lewis *Contd.*]

chiatrists for the courts, do you think these should be done as now, mainly by psychiatrists in the prison service or by visiting consultant psychiatrists, or would you like to see this done entirely outside prison?

*(*Mr *Leadbetter.)* If I could speak first. Entirely outside prison. If I could give a few examples. There is a prison, not a million miles away from here, called Brixton; that prison has a very large number of suicides. Quite a few of the people who committed suicide there were people who had been remanded for medical reports in Brixton. We are told that the problem will go away because they no longer propose to use Brixton as a remand prison. It is primarily in remand prisons where this phenomenon occurs, or at least where the problem is most acute. The problem is not going to go away and remand prisoners will be put in Wormwood Scrubs—this vitiates the whole scheme—except those with psychiatric problems who will be kept in Brixton because of the nearness, and supposed availability, of specialists from the Maudsley and places like that. That vitiates the whole scheme. In our submission we talk about the case of Jim Heather-Hayes, the very first inquest I attended and it made a powerful impression on me. One of the things that emerged was the special study done by HM Prison Inspectorate of Ashford Remand Centre. Both in the publicity we put out—we too are a campaigning organisation—and in the report of the Inspectorate, which was an excellent one, another doctor—not the doctor referred to here who vetted people for punishment—was quite severely criticised. Later there was a very delayed prison suicide study done overall by HM Prison Inspectorate. Once again, without naming the gentleman, this chap was very heavily criticised by implication in that prison suicide study. Imagine my surprise when I went to an inquest the other day where the same doctor is called as an expert witness, and it turns out that the time when we first encountered him he was Senior Medical Officer and he is now Principal Medical Officer in Brixton, probably the most sensitive area as far as suicide risks are concerned. That is the kind of thing that makes us want to weep. This gentleman has amongst his qualifications a Diploma in Psychological Medicine, and an observer in court remarked at the time that he really ought to go and ask for his money because he was cheated! Yet that man's decisions are very important to many prisoners, and you get this whole phenomenon of—what are prison doctors for?—what are prison psychiatrists for? Are they just agents of control or there to treat sick people? It can only be removed by having people entirely outside prison when they are being assessed.

Chairman

532. Have you considered the possibility of a second opinion—not in the case of suicide—but where a prisoner is referred for psychiatric care; now it is delivered by the doctor serving the prison, the consultant psychiatrist. Would you feel the availability of a second opinion from a psychiatrist of the prisoner's own choice might meet the problem?

*(*Mr *Ward.)* Yes, it would be better. There are two points we make in the submission: one is the very striking difference which emerges from the research by Gibbens and his colleagues between recommendations made by psychiatrists outside prison and those made by prison doctors.

533. Could you answer my question?

*(*Mr *Ward.)* Yes. On a second opinion, one thing we are particularly concened about is, with a second opinion it is necessary to get a prisoner sent to a special hospital. In fact, we suggest there should not only be a second opinion but two second opinions.

Chairman: That is three opinions, is it not?

Mr Lewis

534. You quote a recent publication which states that there appears to be no shortage of psychiatrists willing to assess people on bail. Have you any evidence for this that you can quote and give to the Committee?

*(*Mr *Ward.)* I think the evidence for that would be the publication that we quote. I do not have any extensive knowledge, apart from that publication, of the existing state of the psychiatric services. That is from a briefing by NACRO; I do not have it with me.

535. You have no actual evidence. You cannot give me any evidence here and now. Could you send the evidence to us?

*(*Mr *Ward.)* I can send you the relevant document.

536. Then you suggest that the structure of the PMS leads to a tolerance of bad doctors. Others would argue that more important than structure is the level of resources available, the quality of the doc-

[Mr Lewis *Contd.*]

tors and nursing staff recruited, and also the attitude of the Home Office. Would you go along with that and agree with that?

*(*Mr *Ward.)* Certainly I think the quality of doctors recruited is important, but then that again is related to the structure. It may be that the quality of doctors recruited is related to the fact that the Prison Medical Service as a separate entity is not seen by most doctor as a very attractive career.

537. Would you go as far as to say that we have got a third rate doctor in our prisons today?

*(*Mr *Ward.)* I think that there are certainly some. I am not saying that *all* prison doctors are third-rate. We say in our submission that the range of ability is perhaps as great within the prisons as in general practice, but I certainly think there are *some* third-rate doctors in the prisons, and that there are too many third-rate doctors in the prisons.

Mr Galley

538. Is there any evidence that it is worse in prison than outside?

*(*Ms *Tchaikovsky.)* Yes. I think that the evidence we have submitted about the death of Sara Hewer shows that very clearly.

539. That might have been one doctor who was deficient, and it might have happened in the community.

*(*Ms *Tchaikovsky.)* Perhaps I could elaborate. She was in a hospital wing in a prison which does not have any night-nursing cover. You cannot have quality nursing care in a place where you have half the day people in a hospital wing.

540. Is not that a staffing problem rather than a doctor-quality problem?

*(*Ms *Tchaikovsky.)* It is always very hard to give hard and fast evidence. The problem with nurses in Holloway is that they recruit agency nurses in Holloway, and they cannot get enough qualified nurses in Holloway, I have it on good authority, because nurses do not want to work in prisons, they do not like the restrictions on the nursing that they can do, and also they do not like the restraint training. So it does not attract nurses to make a career who are, say, dedicated nurses. It is fair to say that. That is also commonly known, although it is again hard to give hard and fast evidence that will convince *you* of that.

*(*Mr *Ward.)* The difference between prisons and the outside community is that if in the outside community you have what you think is a third-rate GP you can ask to be transferred to another GP, and you will also have the redress available through the community health council.

Mr Lewis

541. Yes, but the other GP outside is not bound to take you on, is he?

*(*Mr *Ward.)* Yes, that is true. We are not saying that the medical services outside are perfect by a long way.

*(*Mr *Leadbetter.)* There is also the point that an outsider, seeing outside patients, seeing free patients, does have rather longer than the three and a half minutes which is what the Wandsworth doctors estimated *they* had to see each patient. These were locums; these were not regular prison medical officers. A great many mistakes were made thereby. Mr Methven, for example, was treated for the common cold and died of bronchial pneumonia, because it was not the common cold, it was severe bronchitis. The prisoners were well aware of that and were trying to draw the attention of the authorities to it, but they were disregarded. Obviously if the doctor had had longer, he might have made a better diagnosis.

Mr Galley

542. But then we all have constituency cases where medical mistakes appear to have been made, to a layman's eye. What is the difference?

*(*Mr *Leadbetter.)* The difference was in *this* case that a coroner's jury, properly advised and with expert medical opinion, said it was a mistake, so it was not just the opinion of any passing layman.

Mr Kennedy

543. The mistake in that case was at least partly attributable to the insufficient time that the doctor has to give each of the individual patients?

*(*Mr *Leadbetter.)* Yes, that is right. Also when we are talking about nurses, I think Holloway is something of a special case, because the vast majority of prison hospital officers of course are *not* trained nurses. There are, I think, only about 100 out of 3,000 who are.

Mr Lewis

544. So I assume from what you say that

[Mr Lewis *Contd.*]

you are not satisfied with the level of nursing care and the medical services inside prison?

*(*Ms *Tchaikovsky.)* In our submission we do say that we believe that is the best reason for disbanding the Prison Medical Service, because it is so bad. This is almost like Kafka for me, because it is so hard to get you to understand what I am saying. If you had ever been in prison and subject to the doctors in there and the way you are treated in there, you might feel very differently. I cannot qualify that enough; I cannot say it enough times.

545. I can only say that on our visits to the prisons—and I think the Chairman and Members will agree with me—we have discussed this question with doctors in almost every prison that we have been to. In our private conversations when we have been meeting people—it has not been on the record, I accept—we have been very free in our discussions in criticising the Prison Medical Service. But from what you have told us this afternoon—and may be there is some case for it—you sincerely believe, as a result of your experience inside, that the present medical and nursing services in our prisons still leave a lot to be desired?

*(*Ms *Tchaikovsky.)* Yes.

*(*Ms *Moore.)* I can honestly say that that is my opinion, because I think that it is incorrect when medical treatment and access to medical treatment are seen as a privilege, and you are allowed that privilege if you can persuade the prison officer that you are ill and if you can get through that vetting. I do not think medical treatment should be seen as a privilege. I can tell you about a certain case. When I was inside, a woman was trying to disguise the fact that she had epileptic fits, because the medical wing of that prison had such a bad reputation that she was scared to be sent there. That is wrong.

*(*Ms *Tchaikovsky.)* That is the same in Holloway. That is true.

546. What recommendations would you like to see this Committee make?

*(*Ms *Tchaikovsky.)* The lifting of the Official Secrets Act, for example, on doctors, to make them fully accountable to the GMC and the BMA; to bring them out from control within a specialist service called the Prison Medical Service, and to have normal National Health Service doctors, including young students and training young doctors in for two years' secondment into the National Health Service in prisons, say, when they are young and keen and will not get institutionalised by prisons. Why should 48,000 people be subject to what I believe is a very second-class medical service? Most prisoners and most ex-prisoners would testify to that.

*(*Ms *Moore.)* Surely the conditions of the hospital wings inside prisons would improve to the standards at least of hospitals, if they were governed by the NHS. If the standard of a hospital wing is in such a bad state that prisoners are scared of being referred there, then I think that is very bad.

Mr Galley

547. Could we go on and discuss further the topic of suicide, if you do not mind leaving this particular topic now? You are rightly concerned about the suicides in prison, and you have given us quite a lot of information about that. How much evidence is there that the suicide rate in prison is higher than that in the community generally?

*(*Mr *Ward.)* It is clearly higher; it is four to five times higher, on the statistics.

548. As much as that?

*(*Mr *Ward.)* Yes.

549. Does that vary significantly from one institution to another?

*(*Mr *Ward.)* Very significantly, between one extreme (Brixton) with five suicides last year, and the other extreme (Grendon Underwood) with no suicides in 10 years, even though it would appear to be a more suicide-prone population—it has been said by Lord Donaldson who was formerly the Chairman of the Board of Visitors that 70 per cent have suicide tendencies. Again the Annexe at Wormwood Scrubs has never had a suicide or even a suicide attempt.

550. Does this relate to the quality of medical service given, or does it relate to the type of people who may be in that particular prison—for example, there might be more mentally-disturbed people in certain prisons?

*(*Mr *Ward.)* I think it relates to the quality of the overall regime. The point about Grendon Underwood and the Annexe at Wormwood Scrubs is that they have a very suicide-prone population, but they have the conditions where they can deal with them in

[Mr Galley *Contd.*]

a very supportive way, using what tries to be like a therapeutic setting, rather than the kind of overcrowding and squalor and general dehumanisation that you get in a place such as Brixton.

*(*Mr *Leadbetter.)* Could I say something also; I was starting to think of this as we finished the last topic. It has great relevance here. The system at Brixton seems to have a fundamental logical flaw. To explain, there are basically two kinds of special watch that are kept on people who are considered suicide risks. What makes one a suicide risk, in formal terms, is another argument. We have had cases where the police, for example, have gone to great lengths to keep someone alive. They have filled in the correct form—which is London is the 618 Form, with a big red F—and sent it in only to have it virtually disregarded by prison doctors, as well as prison warders on the grounds the police were only lay people. Suppose one gets through that net and is recognised as a suicide risk, there are two forms of watch: special watch B which consists of being put in a so-called hospital room—it is indistinguishable from a prison cell—by oneself and looked at every quarter of an hour by someone not empowered to open the door if he happened to be on his own. In the case of a hanging that speed of getting to a prisoner is vital. Special watch A consists of being put in a hospital ward with a whole lot of other people and watched continually. No-one, so far as we can judge, in recent times has contrived to kill themselves in special watch A, a way which works. If you are considered "too disruptive" or "too unpopular", with the other patients in special watch A, which is regarded as a higher form of treatment, you are put on special watch B. In other words, you are in an ordinary cell with every facility for self-destruction and knowledge of the times at which the officers check. If one were so disruptive and so unpopular that meant one was sicker and needed a higher form of care and not a lower form of care, which is under special watch B. There have been 12 suicides in Brixton in two years.

551. Is there no special attention given to try to make sure people under special watch B do not have access to any materials or equipment that would only assist them to commit suicide?

*(*Mr *Ward.)* They take a lot of things to the cell and seem to leave in exactly what you need to commit suicide—a blanket you could tear up and a bar you could tie it round and a chair you could stand on.

552. This is the general practice in Brixton?

*(*Mr *Ward.)* I cannot speak for every prison. Certainly in Brixton in one particular case.

553. If somebody is a suicide risk and if they are genuinely disruptive and so cannot stay on a hospital ward, what do you suggest as being the solution?

*(*Mr *Leadbetter.)* If someone really that sick could not be controlled by experienced hospital officers then they should not be in a prison but a hospital of some kind. That, of course, is the trouble. You have many other categories of people in the population and you have this high proportion of mentally sick people—of course there is—but they are not taken into hospital or special hospitals. There are all these bottlenecks.

*(*Mr *Ward.)* What the police often do when they have a very severely disturbed prisoner is to have someone in a cell sitting with them all the time. There is a long term solution; you would not want to keep them in prison a very long time but that is one way of dealing with it.

554. You suggest that PMS doctors do not pay enough attention to suicide prevention and prisoners having access to a sympathetic outside GP would contribute towards suicide prevention. Why would that be the case? Surely, there is an argument that says there will be less ready access to the outside GP and perhaps a less close relationship with the prison authorities who may be able to do something about it to convince the doctor there is a suicide risk?

*(*Ms *Tchaikovsky.)* There are certain activities in prison which are unique to a prison, such as head banging where prison doctors get inured to that. There is the case of Mark Sancter, and Julie Potter who attempted to hang herself before and set fire to her nightdress. The reason I believe there can be mismanagement or bad record-keeping, I suspect it is more institutionalisation of the doctors, insofar as it must seem like a manifestation of prison behaviour. Unique products of prison behaviour should be normalised and take doctors and everybody living and breathing and working into the outside world and going into prisons so that does not happen. That is why independent GPs working outside and inside it would be healthier for prisoners

[Mr Galley *Contd.*]

and much safer. It would take away the fear of institutionalisation for everyone.

Mr Kennedy

555. Going on to prescribing practices, you have mentioned in your submission how, in certain prisons, there will perhaps be the use of sedatives or hypnotic drugs for those who may be disturbed or have difficulty sleeping, and in other cases for other prisoners there will be the converse example, where somebody has requested this, they cannot sleep or are upset, and it is denied. What is the way through this dilemma in terms of how can the prison doctor strike a balance in the issue, and based on your own observations, what suggestions can you make along those lines?

*(*Mr *Ward.)* There are different medical philosophies and many different doctors. The point we want to make, and the point I know PROP particularly wanted to make had they come today, is the point, being sentenced to prison should not mean being sentenced to a particular medical philosophy. If you felt the doctor treating you had a medical philosophy you felt uncomfortable with, that you should have the opportunity of being treated by somebody else.

556. It comes back to what we were talking about?

*(*Ms *Tchaikovsky.)* It is very complex that problem; it does not just come down to drug or not to drug. Some prisons have a gymnasium, activities and work and drug-taking goes down. If prisoners are locked up for 22, 23 hours a day it is called, "sleep your time away", or, "do your bird on your pillow". There are lots of things that have a bearing on that as well as the philosophy of the prison doctors.

557. Putting that within the prison context, I agree with you very much, it is extremely complicated, that issue. In fact, going back to what you were speaking about under Mr Galley's question about suicide, you would come down firmly to the view those with behavioural problems should not be inside a prison setting to begin with. You would all subscribe to that?

*(*Mr *Ward.)* Grendon Underwood and the Annexe at Wormwood Scrubs are able to cope with prisoners with relatively low amounts of drugs.

*(*Ms *Tchaikovsky.)* Low amounts of violence, and control reports and a report system. It is a modern prison as far as prisons go but it seems to be the only one.

*(*Mr *Leadbetter.)* There is a confusion too in everybody's minds and, certainly for most people who have anything to do with it, between mad and bad. You use the terms indistinguishably almost, and one man's control is another man's therapy. There is that problem always.

558. What do you say should be done to people with severe behavioural problems, from hurting themselves and hurting others?

*(*Ms *Tchaikovsky.)* We advocated a protective room a couple of years ago, before the Home Office, which is now being installed in Holloway. Obviously if you have women banging their heads, like Christine Scott who died from head banging, you have to have a protective room. That is the base line. But it has to be recognised that that is a manifestation of despair.

559. That is a final solution, to some extent?

*(*Ms *Tchaikovsky.)* Exactly. So we are looking at the phenomenon of utter despair in people. So obviously you take away the reasons for that despair. I would have thought that that was the answer—find the causes, rather than just have a protective room for the person involved.

Sir David Price

560. With regard to many of the things that you are telling us about that you want to see changed, how far do they really lie within the medical service, and how far are they the total conditions within individual prisons, which are so confining that they themselves create or aggravate all these problems, so that mere improvement in the Prison Medical Service would not make very much difference!

*(*Ms *Tchaikovsky.)* It would go some way towards it. That is what we are saying. People have said this to us. They say, "Why are you battling away for this? Look at the treatment that people get from their doctors in the community". I hear what they are saying, but we have got to make inroads, if we can, to have prisons opened up, in a sense, to the community, and normalised, because otherwise people will, I believe, be abused within that system. So I think that certainly the conditions aggravate that. As I said, the restrictive practices of the POA

[Sir David Price *Contd.*]

even have a large bearing on the matter. Doctors cannot carry all the blame, that is for sure. But imagine if we could just normalise prisons and have priests coming in from the outside and not employed by the Home Office, doctors coming in from the outside and not employed by the Home Office, educationalists coming in from outside.

Mr Lewis

561. Do not priests come in from the outside now?

*(*Ms *Tchaikovsky.)* No, they are employed by the Home Office. I think that prison is the last place where the Church is in the pay of the State.

Chairman

562. What information do you have about the experience of women who have babies while they are in prison, while they are sentenced? Do you think that there are any signs that the women's prisons are becoming any more humane in the treatment of women in that particular circumstance?

*(*Ms *Tchaikovsky.)* I think we have seen improvements, certainly. For example, the governor at Styal, Jim Anderson, is the man who called for parole in confinement. There are changes that are happening there. One of the improvements is that in the old Holloway where there was a place called K Wing—which you may have visited—for mothers and babies; it was like a little cottage in the prison.

563. They had a nursery, did they not?

*(*Ms *Tchaikovsky.)* Yes, they had a nursery, they had a garden, they had their own cookers and cooking facilities. Now we have a wing in the regular prison, and this is the shift to this new technology high-techprison. Again going back, I am sorry to keep saying the word "normalising", but I would have thought that that was far worse.

564. What was that reference to high technology?

*(*Ms *Tchaikovsky.)* This shift in prisons. They have electronics around them. The wings are not like they used to be. They certainly have not got a little cottage in the grounds, like K Wing.

565. We did not see much high technology in Holloway or in Styal for that matter.

*(*Ms *Tchaikovsky.)* No. Cookham is the newest high-tech prison, and Durham H Wing. What they have done there is creat what we have called a high-tech wing. Bu there is certainly an improvement betwee governors and officers and mothers an babies. We have seen that. I would b worried about the new buildings if the were going to go down the high-tech roa for mothers and babies.

566. What we saw in Styal was reall very attractive in many, many ways, and i very good condition, in good surroundings The mothers, of course, are encouraged t look after their babies—unfortunately no all the mothers want to do that, so that i another problem—which places consider able responsibility on the women staff o the prison, does it not, to encourage goo mothering and feeding and that sort o thing?

*(*Ms *Tchaikovsky.)* Yes.

567. Do you think that there is enough o that done?

*(*Ms *Tchaikovsky.)* I must say that we have done very little work in this area, and for a very good reason. We are very concerned that if we argue that prison is no the place for babies as it is, they may well say that mothers should go into prisons without their babies. So we have been extremely low-profile on the question o mothers and babies.

568. If you had a free hand to organise the women's side of the prison service, what would you like to see introduced?

*(*Ms *Tchaikovsky.)* What a lovely question! Educational prisons, prisons where there is basic literacy, where there is support.

569. I am thinking particularly of mothers with babies. We all agree about education, I am sure.

*(*Ms *Tchaikovsky.)* I actually think that I would not believe there was ever a question of sending a mother with a baby to a prison. I do not think that prison equals mother and baby, or mother and baby equals prison.

570. Sometimes she is pregnant when she goes to prison and has to deliver the baby in prison, under sentence.

*(*Ms *Tchaikovsky.)* Then, like Jim Anderson, I think she should go out on parole. I do not think prison is a place for mothers and babies.

[Chairman *Contd.*]

571. So what would you do? If the law has been broken, what would you do?

*(*Ms *Tchaikovsky.)* For starters, there is an absence of, say, hostels for mothers in the community, on the lines of bail hostels where a mother would be taught home economics to help to bring up the kid, supported by other women in the community, not in prison. I really do not think they should be born in prison at all.

Mr Lewis

572. We are assured that there are no babies actually born in prison.

*(*Ms *Tchaikovsky.)* No, there are not.

Chairman: They are not born in prison.

Mr Lewis

573. The lady said "born in prison".

*(*Ms *Tchaikovsky.)* No. I am sorry, I take that back.

Chairman

574. Do you think that women have different problems in prison from men, which ought to be taken more into account by the Home Office in the provision of medical facilities?

*(*Ms *Tchaikovsky.)* Certainly. There should be more gynaecologists.

575. Apart from the childbirth point which we have discussed and post-natal care, what else?

*(*Ms *Tchaikovsky.)* More women doctors, certainly. There are not enough women doctors in the Prison Medical Service. I forget the figures; I know they are very few. Also I think it is too easy to say that the reason women take so many more drugs in prison than men do is because women take more drugs in the community than men in the community. I think that is too easy to say. The incidence of drugs in women is very high, so I would like to see that brought down.

576. What about this problem of association? We did find that sometimes the women are not encouraged to associate with each other within the prison building.

*(*Ms *Tchaikovsky.)* Certainly that is true. There is very little association. But again that goes back to prison officers.

577. Why should that be? The men appear to be able to associate.

*(*Ms *Tchaikovsky.)* Again I think that understaffing is at the core of it, because if less than a certain number of officers are in a prison, the prison task drops then. So it is a security element. I think it is right to say that. There has been a problem with recruiting women officers, with getting women officers to do overtime. That is the reason there is no association for women. I do not think it is discrimination just because they are women as opposed to men; I think it is staffing problems that have caused that. That said, 22 to 23 hours a day locked up is a dreadful situation.

578. Supposing we cannot get the sort of structural changes in the Prison Medical Service that all of you would like to see; what ideas would you put forward to us for improving the situation, short of that? Do you think that some kind of outside inspection system, for example, would help, some obviously independent system? Do you think that that could add something to improving the situation?

*(*Ms *Tchaikovsky.)* Yes.

*(*Ms *Moore.)* Yes, that would improve the situation, because if the standard in hospital wings in prisons was brought up, then maybe that would reduce some of the fear that women prisoners, I know for a start, have of those prison hospital wings. If someone is afraid to ask for medication, and you remove the reason for that fear, then that has got to be an improvement. If the standard of those wings is brought up, then it can only help.

*(*Ms *Tchaikovsky.)* An academic chair of prison medicine too, to upgrade the whole thing, to get better pay, better conditions, better qualified doctors, to normalise that and get the normal medical training.

579. There are lots of professors of psychiatry who are very knowledgeable about prison medicine, who are in and out of prisons all the time.

*(*Ms *Tchaikovsky.)* I think that has just knocked down my argument for a chair in prison medicine, in that case! If you could not see your way through the National Health Service, I think that it would be a gain to upgrade the system, to upgrade the pay and conditions, to attract people to it, to have locums after hospital training to do this as part of their training as doctors. There is quite some unemployment for doctors at this time, as I understand it. They could actually take on two years' service in prisons.

580. If you say you favour some scheme

[Chairman *Contd.*]

of outside inspection, who do you suggest should do it?

*(*Mr *Ward.)* Ordinary environmental health officers.

581. What about you—you have been very silent for some time now?

*(*Mr *Leadbetter.)* I was pondering the changes one could make, short of Utopia. I rather regretted that you asked the question, it implied that we do not stand a cat in hells chance.

582. We need to have some alternatives. We have not decided what recommendations we are going to make; that is why we are talking to you, to get ideas to recommend to the Home Secretary.

*(*Mr *Leadbetter.)* One thing that should be the case is that we should look again at the question of a patrolling discipline officer not being able to open the door of a cell when he sees somebody hanging. In the Glenochil Fatal Accidents Inquiry the person who conducted the inquiry gave short shrift to the argument that the chap might be preparing an ambush and told this officer it was his job to open the door and go in, because one dies within four minutes or becomes brain dead within four minutes, unconscious within seconds. People could be saved, and sometimes are saved by chance, the chance that somebody is there. In Brixton—we have given poor Brixton rather a hammering—in two or three cases we have dealt with under the special watch B system, in addition to the horizontal patrolling officer going along the landing, there was a vertical officer going up and down stairs. Two officers could have opened the door. It should not be beyond the wit of a prison governor to have a system where two officers patrol together. If they notice anything strange they can open the door without risk. It is that kind of thing.

583. Could you get back to the question about the Prison Medical Service.

*(*Ms *Tchaikovsky.)* Hospital officers only to be from qualified nursing staff.

*(*Mr *Leadbetter.)* There are a great many unemployed nurses. Broadmoor does not seem to have any trouble getting nurses, even if they belong to the POA. It should be possible to staff hospital wings with a large proportion of qualified nurses. Also, I think if it were possible, if we are still going to have some system with the PMS unabolished, it might be worth trying to have a separate doctor, or maybe a rota system so that everybody clearly knew who the doctor was, all those employed in these unpleasant functions, like vetting people for punishment.

584. Would he be a doctor coming in from outside or a doctor employed from within the Prison Medical Service?

*(*Mr *Leadbetter.)* The chap has to be one employed within the Prison Medical Service full-time.

585. What about the idea of some outside kind of inspection, who would be appropriate to do that?

*(*Mr *Leadbetter.)* H M Inspectorate did a fine job at Ashford with the recommendations they made there for suicide prevention, and some of the other features were excellent.

586. An extension of that kind of organistion?

*(*Mr *Leadbetter.)* Yes. I would like to see them free from political constraints. When they did a special report on Ashford it was fine. The actual prison suicide study was more than a year late and bore all the hallmarks of having been re-written about ten times so that it did not say anything too abrasive.

587. You did not get hold of the first draft copy?

*(*Mr *Leadbetter.)* No.

*(*Mr *Ward.)* One thing I would commend to the Committee, if you have not already read it, the report of the review of suicide precautions at Glenochil.

*(*Ms *Tchaikovsky.)* Also the special health authority institution by Larry Gostin when he was at NCCL.

Chairman: I think that concludes our questions. Thank you very much indeed, we are very grateful to you.

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HOUSE OF COMMONS

SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

Wednesday 19 February 1986

Prison Reform Trust

Dr Stephen Shaw, Ms Una Padel and Dr Julian Candy

MIND

Ms Christine Shaw, Mr William Bingley and Mrs Audrey Peckham

Dr Maurice Rosen

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WEDNESDAY 19 FEBRUARY 1986

Members present:

Mrs Renée Short, in the Chair

Mr Tony Favell
Mr Roy Galley
Mr Charles Kennedy
Mr Terry Patchett
Sir David Price
Mr Nicholas Winterton
Mr Tim Yeo

Memorandum submitted by the Prison Reform Trust

1.1 The Prison Reform Trust is a national charity established in 1981. The Trust's aims include the promotion of debate about prison conditions and the encouragement of community interest in penal establishments. The Trust provides advice to prisoners and their families, organises talks and lectures and has run a unique series of social action projects—Prison Weeks—designed to improve public awareness of the penal system. In addition, the Prison Reform Trust endeavours to play a full part in developing public policy by issuing briefing papers, reports and articles and by conducting its own research. Work in hand includes a study of the Prison Rules and their relationship to the European Standard Minimum Rules for the Treatment of Prisoners, a series of papers on Immigration Act prisoners and a report on the parole system.

1.2 The medical treatment available to prisoners is frequently the source of controversy. For that reason, the Prison Reform Trust greatly welcomes the Social Services' Committee's inquiry into the prison medical service. We welcome too the opportunity that it affords for improvements to an area of medicine widely (but not always accurately) believed to lag behind standards in the community as a whole.

1.3 Some time before the announcement of the Committee's inquiry, the Trust had already decided to solicit contributions for a book on prison medicine. That book is now in press and we will be circulating copies to members of the Committee in advance of publication in September. Included among the contents are articles on mentally abnormal offenders, radiography and on the treatment of addicts in the Wormwood Scrubs Hospital Annexe. There is also an article comparing the prison health services of England and Wales, Scotland, Northern Ireland, Holland and the United States and an article by an American contributor which discusses the progress of the American Medical Association's "jail program" from its beginnings in the 1970s.

1.4 Two of the articles which we regard as of particular significance are included in this volume of evidence. They are, respectively, Dr Julian Candy's account of the relationship of the Prison Medical Service to the National Health Service* and Dr Tony Whitehead's analysis of the use of psychotropic drugs in prison.* The first section of our evidence consists of a discussion of those themes which we hope the members of the Committee will concentrate upon in their own deliberations. (It should be added that, other than as contributors to our book, neither Dr Candy nor Dr Whitehead are formally associated with the Prison Reform Trust and they bear no responsibility for this memorandum).

*Not printed.

The cost of printing and publishing these Minutes of Evidence is estimated by Her Majesty's Stationery Office at £4,212.

THE CONTEXT OF PRISON MEDICINE

2.1 We should state at the outset that in our view it is no more possible to divorce th question of prison medicine from the wider issues of sentencing policy and priso conditions that it is any other aspect of prison life. It cannot be emphasised too often tha this country's use of imprisonment is totally disproportionate to its effectiveness and tha prison rules, regimes and physical conditions are—in those much quoted words—a affront to a civilised society. Indeed, these factors are crucial to any understanding of th level of morbidity amongst prisoners and to the conflicting roles which prison doctors mus play. As Dr Richard Smith has acknowledged:—

"After spending 18 months investigating prison health care I believe that there is ampl scope for improving both the health of prisoners and the quality of prison health services The single change that would probably do most to improve both would be to reduc drastically the number of prisoners".

Prison Health Care, 1984, p. 17(

2.2 The relationship between general prison conditions and the incidence of ill-healt among prisoners was illustrated by the effects of the prison officers' industrial action i 1979 and 1980. The consequent reduction in overcrowding and increase in association fo prisoners was recorded by the Home Office in the following terms:—

"Medical officers in several establishments reported that the incidence of inmate requesting to see the medical officer fell during the period of industrial action. This wa attributed to a lessening of tension as a result of the reduction in overcrowding couplec with an increase in free association due to the closure of the workshops".

Prison Department Report 1980, Cmnd 8228, Para 210

2.3 A further example of this relationship between the prison regime and the prevalance of medical and control problems is shown by the experience of the Wormwood Scrub Hospital Annexe, which operates as a therapeutic community for addicts and sex offenders In over twelve years there has not been one suicide attempt in the Wormwood Scrub Annexe, no psychotropic medication is prescribed and there has been virtually no violence either between patients or against staff. The number of consultations with the medica officer is also far lower than amongst the prison population as a whole. It is a quite remarkable indictment of the priorities of the Prison Department that the Wormwoo Scrubs Annexe has on several occasions been threatened with closure and that no simila unit has been established in any other prison.

2.4 We would conclude that whatever improvements may be made to the organisation and standards of prison health care, they are unlikely to achieve dramatic results unless a real effort is made to diminish the level of imprisonment itself.

"NORMALISING" THE PRISON ENVIRONMENT

3.1 We should also make clear the question of the possible integration of the prison medical service into mainstream health care is in our view to be properly regarded as only part of the wider issue of the relationship between the prison and the community as a whole.

3.2 The disadvantages of the continuing isolation of the prison medical service have been effectively described by Dr Paul Bowden:—

"... a separate state system for a minority group tends to be seen as a poor standard system recruiting the worst rather than the best categories of staff and, if the quality of personal service is low, there is a danger that there will be less freedom of choice and more felt discrimination".

"Ethical aspects of the role of the medical officers in prison", in *Medical Services for Prisoners*, 1978, p. 29.

However, what is needed in the prison system is a comprehensive package of measures to "normalise" the prison environment. It is not just the medical, but the educational, occupational and welfare facilities available to prisoners which should be integrated as far

is possible with those provided in the community. As many different agencies as possible should be encouraged to have responsibility for aspects of prison life.

3.3 Only if prisons become what the Home Office itself has termed "community prisons" can standards be properly improved and prisoners prepared fully for their eventual release back into society. In this evidence we will argue for incorporation of the Prison Medical Service into the NHS; but incorporation of the medical services alone, while desirable in itself, is not enough.

3.4 One small but significant step towards "normalising" imprisonment would be achieved by permitting prisoners to retain proprietary medicines in their cells. We doubt if there is any real benefit in a system which insists that prisoners must go to the dispensary when suffering from indigestion or a headache.

The Five Main Problems

4.1 In our judgement there are five main problems which arise from the current practice of prison medicine. These are:

(i) Excessive secrecy

(ii) Recruitment and training

(iii) Prescription practices

(iv) The treatment of the mentally ill

(v) The difficulties created by the close identification of prison service doctors with the administrative and disciplinary structure of penal institutions.

We consider each of these problem areas in turn.

Excessive Secrecy

5.1 The policy of greater "openness" which it is frequently stated now attaches to prison affairs in general has hitherto been conspicuous by its absence in relation to prison medicine. However, recently a number of commentators have called on prison doctors to be more openly critical of prison conditions. Dr Benjamin Lee, who resigned in 1983 as medical adviser to the Prison Inspectorate, has advocated "a more forthright and public stance" on the part of prison doctors, enjoining them to "stand up and be counted" and to open up "their clinical actions and records to independent scrutiny by their professional peers". Noting the restrictions currently imposed by the Home Office, Dr Richard Smith has written that prison doctors should able to speak out on the problems they face in the prison system.

5.2 The Prison Department itself has suggested that the prison medical officer's "clinical independence and . . . professional responsibility for the health of inmates . . . enables him to act, on occasions, as an independent referee of the system". But for our part, we find it difficult to think of many occasions when prison doctors have publicly blown the whistle in this way. Indeed, it is apparent that not all prison doctors welcome publicity. The editor of the restricted and now defunct *Prison Medical Journal* wrote that she had been trying unsuccessfully for years to persuade the authorities that the journal should be publically available: "paranoid comment is fed by lack of information and refuted by evidence". By contrast, in a contribution in the same journal on the clinical treatment of sex offenders, a visiting psychotherapist stated: "publication of an article such as this in any medical publication available to persons outside the prison service could excite such hostility as to accentuate the problem".

5.3 The Trust believes that confining the *Prison Medical Journal* to a restricted circulation exemplified that excessive regard for secrecy to which prison medicine has been prone. However, we also regard the demise of the Journal as a matter for regret. Insofar as the medical treatment of prisoners may pose special problems it is surely essential for there to exist some forum in which new developments may be disseminated, assessed and discussed. As the Director of the PMS, Dr John Kilgour, has himself written:—

"I believe that a better understanding of the work of the prison medical service among wider professional group will do much to minimise the criticisms made which so ofte arise from ignorance".

British Medical Journal, 288, p. 160

5.4 However, we do not think that the question of prison conditions can be addresse simply by advocating a more open approach on the part of prison doctors. The Prisc Reform Trust fully supports the demand for a code of minimum standards c imprisonment which can be independently audited. We believe for example, that there is role for Public Health Inspectors in ensuring that adequate standards of hygiene are me The Trust also recommends that, even without radical changes in the structure of the PM responsibility in overseeing prison health care should rest with the relevant Communit Health Councils.

5.5 A more open approach by prison doctors would, however, help overcome some c their present isolation from the medical profession as a whole. It is inevitable that priso medicine lacks much of the diversity of general practice: there are few women patients an no children for example. But it may also be the case that full-time prison doctors simpl lose touch with new theories and techniques which are more speedily disseminated in th NHS.

Recruitment and Training

6.1 Over 20 years ago the Working Party on the Organisation of the Prison Medica Service (The Gwynn Committee) bemoaned the fact that:—

"The service has had difficulties for many years in attracting sufficient recruits of suitabl calibre and qualifications."*

Report of the Working Party on the Organisation of the Prison Medical Service, 1964, Para. 9.

6.2 Shortage of both full-time and part-time doctors to staff the Prison Medical Servic has continued over the intervening two decades. The Gwynn Committee's proposal fc joint appointments between the PMS and the NHS was tried, but found wanting. Althoug it would be wrong to suggest a great crisis of morale amongst prison doctors, it is proper t admit that, as former Parliamentary Under-Secretary of State at the Home Office, Lor Elton, has said: "The rewards and job satisfaction in the prison medical service (are) les than in general practice."

6.3 Concern about recruitment and training is not, however, confined to prison doctors The Prison Officers' Association has condemned the training of hospital officers a "nothing more than an extended first-aid course" and the Royal College of Nursing ha said that "in view of the large numbers of inmates who require medical and psychiatri treatment whilst serving prison sentences, the type and amount of training for priso hospital officers is grossly inadequate'. The Home Office aim to increase the proportion o hospital officers with professional nursing qualifications to 30%. At present only 74 out of total of around 900 hospital officers have such qualifications.

6.4 We believe that the problems of recruitment and training flow directly from th existence of a separate medical service outside the NHS. In particular we are extremel unhappy that the low level of training for hospital officers seems to result from the Hom Office's wish to keep costs in this area to a minimum. Women prisoners are cared for b fully trained nurses. Male prisoners should be treated in exactly the same way.

Prescription Practice

7.1 Without doubt, the most controversial and emotive issue in the whole debate abou

*C.f. The conclusions reached 60 years ago by Stephen Hobhouse & Fenner Brockway: "Medica officers of good calibre are rarely attracted to the prison service." English Prisons Today, 1922, p. 261

prison medicine is prescription practice. The most sensational criticism of recent years may be found in an editorial entitled "Perverted medicine" in the magazine *World Medicine*:—

"... a senior and respected member of the medical establishment has urged us to bare the disturbing and repugnant scandal of what some doctors—not independent practitioners, but doctors in the pay of the State—are doing in the prisons. Worse still is the professional humbug which effectively condones their dubious medical ethics as they cynically dose prisoner-patients to the eyeballs, sheltering their culpability in the tacky embrace of Home Office secrecy ... it is maltreatment that is *routine* ... there are men and women in our prisons who are receiving what amounts to punitive medicine, something most people identify with Siberia."

World Medicine, 30 October 1982, (Emphasis in original)

7.2 In the Trust's view, as an overall description of prison medicine, such an account is palpably inaccurate. While this is not to deny the serious anxiety which exists over the use of psychotropic medicines, over the last few years there seems little doubt that prison doctors have *in general* cut back severely on their use of drugs. There have been suggestions that this, in turn, has created problems for some prisoners denied the medication which they had previously been prescribed.

7.3 It was not until June 1980 that the Home Office published statistics on drug dosage levels. It is regrettable that the way in which these statistics are presented is such as to limit their usefulness. (The word "dosage" is particularly unhelpful. The Chief Pharmacist at Wormwood Scrubs told the Parliamentary All-Party Penal Affairs Group in January 1982 that he could supply Largactil in syrup form or in suspension. Five milligrams of either would count as one dose, but the suspension is four times as strong as the syrup.) The Trust cannot believe it beyond the capability of the Home Office to issue information on prescription levels in a more meaningful form.

7.4 Despite this criticism of the statistics, we have been pleased that the yearly dosage totals do appear to show a substantial decline in response to public pressure. The dosage rate at Holloway, for example, has fallen in three years from three doses per prisoners per day to one dose per prisoner per day. It is interesting to note Dr Benjamin Lee's impression:—

"... that prison doctors have become so sensitive to media criticism that they are just as likely to withold doses of psychotropic drugs. It is true, though, that doctors may administer, or countenance the administration of, psychotropic drugs to achieve what the disciplinary staff want—a quiet prison."

World Medicine, 6 August 1983

7.5 Prescription practices in women's prisons have been a particular source of controversy and the Trust joins those who are seeking an independent medical study of this issue. The question of medication levels amongst women prisoner-patients seems related to a now outmoded medical/psychiatric model of female criminality.

7.6 A wider debate has concerned the alleged prescription of drugs for control purposes. In response to such criticism, it has become conventional for Ministers to deny that medicine in prisons is ever used other than as a "treatment". For example, Patrick Mayhew told the House of Commons in 1982:—

"The prescription of a medicine for a prisoner is a matter for the professional judgement of the responsible prison medical officer. The prison medical service has complete clinical freedom and the same ethical standards as doctors practising elsewhere."

Hansard, 26 October 1982

7.7 By contrast, prison doctors themselves have admitted that the line between treatment and control is crossed:

"Why is it that we consider it quite appropriate to control children when they behave in an anti-social way but, when those children grow up and arrive at chronological adulthood with the emotional age of a greedy two year old, controlling suddenly

becomes questionable and challengeable in the political arena? But treat them an control them we must, and we should make no bones about saying that is what w do. . . ."

Prison Service Journal, 19, 197

7.8 We would not claim for ourselves the ability to resolve this grey area betwee treatment and control. However, we are firmly of the view that the present position c prison doctors—described by one medical officer as "all part and parcel of the prison sta team"—makes them subject to pressures to prescribe medication in the interests of th institution rather than in the sole interests of their patients.

THE TREATMENT OF THE MENTALLY ILL

8.1 It has now become almost a commonplace to bemoan the detection of mentall disordered offenders in prison establishments. Successive official enquiries have draw attention to this scandal, but until recently precious little has been done to produce remedy. The diversion of money away from Regional Secure Units by the responsibl Health Authorities is evidence of the low priority which has actually been attached to thei establishment. The total sum effectively misappropriated exceeds £20m. Some of th money allocated was spent on pay awards for senior medical staff and even for payin VAT to the Exchequer.

8.2 Considerable hope has been invested in these new Regional Secure Units, but giver the likelihood of a high demand for places from the Special Hospitals and from psychiatri hospitals there must be some doubt whether they will in fact succeed in reducing th numbers of mentally ill people in prison. Larry Gostin has suggested:—

"Given the attitudes of some members of staff in local hospitals, demand for secure bed may continuously increase to meet available supply."

A Human Condition, Vol 2, 1977, p 142

8.3 Howsoever the Regional Secure Units may be used, there is in any case considerable disagreement as to the numbers of mentally disordered offenders currently held in prison establishments. Nor is this solely the result of the admittedly formidable problem o defining "mental disorder". For it appears that as the chances of actually effecting a prisoner's transfer from prison to psychiatric hospital have declined, so prison medical staf have been less likely to make such recommendations. According to an article in the *Prison Medical Journal*, the criteria for admission to Special Hospitals only derive partially from mental state:—

"Some patients had very little evidence of psychiatric illness but were still accepted. The psychiatric differences between the patients who were accepted and those who were rejected were marginal. Mental state, in other words, was not a significant criterion for admission to a mental hospital. It is much more likely (and here I speculate) that the mental state was used to support or justify a decision made primarily on other grounds."

Prison Medical Journal, 16, 1976

8.4 The Prison Reform Trust believes there is a strong argument for further research on the whole issue. It is profoundly unsatisfactory that the most comprehensive recent survey of the prison system—the May Enquiry of 1979—should have to report its inability to establish precisely the numbers of mentally disturbed offenders in prison cells.

8.5 In 1982 the House of Commons Home Affairs Committee recorded:—

"It is intolerable that people whose offences spring from a mental disorder should be detained in prison rather than in a secure hospital, and it is just as indefensible for the National Health Service to refuse treatment to someone requiring treatment for mental illness, as it would be if the NHS refused to treat an accident victim or someone suffering from a physical disease. We recommend that legislation should be introduced to require the provision of NHS places for any mentally disordered offenders on whom the courts make hospital orders."

Fourth report from the Home Affairs Committee, *The Prison Service*, HC 412, 1981

However, this recommendation was rejected by the Government. Accordingly, it remains the case that the principal reason for the continued detention of mentally disturbed offenders in prison is the practical difficulty of finding a consultant prepared to make a bed available.

8.6 We believe that until the transfer out of prison of all mentally disturbed offenders can be effected, there is a strong argument for implementing the recommendation which the House of Commons Expenditure Committee made in 1978 and ensuring that the DHSS pays for their accommodation in prison.

8.7 The standard of that accommodation varies widely. Some prison hospitals compare favourably with hospitals in the wider community. Regrettably, there are also some which barely merit the description "hospital" at all. One of the worst which we have seen is in the small local prison at Bedford. This has been described (in the measured tones employed by the Prison Inspectorate) as follows:

> "The prison hospital was located in a single-storey building which was clean and well maintained. It comprised seven single rooms, a 2-bedded ward, two stripped rooms and one protected room, offices, a treatment room, a dispensary and a small room which was used as a dental surgery and by the optician. Patients had no association area and no television room. Inmates remanded in custody for medical or psychiatric reports are normally kept under observation in the hospital. However, the hospital accommodation is so limited that many inmates who would normally be admitted are returned to their cells on the wings."
>
> *H M P Bedford: Report by HM Chief Inspector of Prisons*, 1984, Para 3.20

8.8 We are seriously concerned that conditions of the kind described above may actually exacerbate mental disturbance. Without in any way acquiescing in the use of prisons to detain people who are mentally ill, we believe that the improvement of hospital accommodation should receive a higher priority in the Prison Department's programme of capital spending.

The Difficulties Created by the Close Identification of Prison Service Doctors with the Administrative and Disciplinary Structure of Penal Institutions

9.1 It is in our view a very sad commentary that the many references to the need to transfer mentally disturbed offenders out of prison have had so little impact. It must also be admitted that the frequently voiced demand for the disestablishment of a separate prison medical service has also had little impact on public policy and has probably contributed to prison doctors' own sense of isolation. For example, the former Acting Director of the Prison Medical Service criticised those:—

> ". . . who seem determined to challenge so to speak, the Establishment, with an almost pathological tenacity on the grounds that the medical care given to prisoners cannot be proper because it is not under the direct aegis at the National Health Service."
>
> *Royal Society of Health Journal*, 4, 1979, p 158

9.2 It may certainly be agreed that it is naive to regard incorporation of the prison medical service into the NHS as a panacea. Standards of health care in the community differ from district to district; in general, the already disadvantaged suffer higher morbidity and receive a poorer level of service. Nor could mere administrative incorporation necessarily guarantee a prisoner's right to choose his or her doctor, nor in itself remove the conflict of interests inherent in prison doctors' dual loyalty to the institution and to their patients. What the Prison Department has described as the medical officer's "vital role in the management of the establishment and (contribution) to its effective operation" would not disappear if prison doctors were employed by Health Authorities rather than by the Home Office. Indeed, the Prison Inspectorate has recently recommended an extension of the prison doctor's role to include a special responsibility for suicide prevention.

9.3 We have already referred (in paras 7.3 and 7.8) to the pressures which may be felt by prison doctors to prescribe medication in the interests of a quiet prison. It is instructive to list those many subjects upon which the medical officer, as a member of the senior

management team, is expected to advise. They include food, hygiene, working conditions the suitability of candidates for employment in the prison service, fitness of members of the service, accidents to prisoners and staff, assaults upon prisoners and staff, fitness fo adjudication, self-injury, food refusal, petitions to the Home Secretary and fitness o prisoners for transfer.

9.4 These additional responsibilities are clearly regarded by the Government as a positive advantage to the prison service. In its 1981 statement arguing against re-organisation of the PMS, the Home Office stated:—

> '... were the National Health Service to take over the provision of medical services in establishments, these duties would have to be divided between various agencies, and there would no longer be one person in an establishment responsible for medical matters there would be a real risk of conflicting priorities and contradictory advice."
>
> *Prison Department Report*, 1981, Cmnd 8543, para 250

9.5 We do not believe that contradictory advice is necessarily undesirable. The responsibilities of prison doctors to declare whether prisoners are fit for punishment and their power to determine which prisoners should be transferred to Special Hospitals are just two of the areas where a prison doctor's responsibility to his patient and to the institution may conflict. As Dr Paul Bowden has said:

> "It is not possible to be responsible for the physical and mental health of a prisoner and also to sanction his punishment, on the grounds that he is fit to receive it, by methods which may be prejudicial to health."
>
> *Medical Services for Prisoners*, 1978, p. 29

9.6 In our view, the case for abolition of the prison medical service is buttressed, not weakened, by the range of institutional responsibilities which prison doctors currently bear.

Conclusions

10.1 In this submission we have concentrated upon those areas of prison medicine which we believe to be most crucial to the Committee's enquiry. We are aware, however, that there are other important aspects to the medical treatment of prisoners (for example: standards of radiography, facilities for drug addicts, suicide prevention) which we hope the Committee will also consider.

10.2 We have made proposals on specific issues but our central thesis is that the division between the Prison Medical Service and the NHS can no longer be justified. The Prison Reform Trust believes that integration of the two services would improve standards of patient care and go some way to removing the ethical problems which currently face prison doctors. Moreover, we regard changes in medical arrangements as part of a general process of reducing the gap which presently exists between prisons and the wider community.

Examination of Witnesses

Dr Stephen Shaw, Director, Ms Una Padel, Deputy Director, Prison Reform Trust and Dr Julian Candy, Consultant Psychiatrist, St John's Hospital, Aylesbury (former member of Parole Board), called in and examined.

Chairman

588. Thank you very much for the document that you sent us, which contains a considerable amount of information. We would like to put some questions to you. You suggest that a prison doctor's responsibility to his patients and to his institution may be in conflict in determining whether a prisoner should be transferred to a special hospital. Are you implying that prisoners are sent to special hospitals because they are troublemakers?

(Dr Shaw.) There was some evidence which we were able to cite in our written evidence that suggested at least in the past this has happened. Certainly it is recognised that in general the dual responsibilities of prison doctors to prison management and to

[Chairman *Contd.*]

prisoners as patients may, indeed, conflict. The question of transfer to special hospitals is only one area where that conflict may occur. I think there are others as well.

589. So you are suggesting that prisoners can be transferred without necessarily being in need of the psychiatric care that a special hospital is supposed to give?

*(*Dr *Shaw.)* Again I must refer to the written evidence. We were only able to give one individual example where a prison doctor himself was suggesting that was the case.

590. You say there is little doubt that prison doctors in general—not all but in general—have cut back severely on the use of drugs in recent years. What is your view about that? Are you pleased with that or do you feel they may have gone too far?

*(*Dr *Shaw.)* If I may say something about drugs generally, it is often difficult to disentangle those statistics which the Home Office does provide because of the way in which they group together numbers of prisons, because of the ambiguity over the term "dose" and because of the groupings of particular types of psychotropic drugs. Having said that, based on both the published statistics and what we have been able to pick up in confidence from prisoners and prison doctors, certainly in the adult male prisons there is no question that dosage levels of many types of drugs have been cut back. I am less certain whether that has been the case or whether it has gone far enough in the women's prisons. As far as I am aware, there has been a general move towards lower levels of prescription and I am satisfied with that. One of the problems which doctors in the prison service face which their colleagues outside do not face is that there is a general trend toward cutting back on prescriptions of psychotropic drugs, particularly tranquillisers, in the community but if a doctor in the community does endeavour to do that there are a number of other types of therapy which he would endeavour to use. Relaxation therapy would be the obvious one. Those sorts of facilities are often not available within the prison.

591. Does either of you want to add anything to that about the use of drugs?

*(*Dr *Candy.)* Yes. I think it is a very fair comment. In the community, certainly in the last few years, there have been big efforts made to use these drugs more wisely and more sensibly but that does entail providing other sorts of help for these patients. Psychological help and help from psychiatric nurses are two major areas where that has moved ahead in the last few years.

592. But if they are not available how do we manage that, because they are in quite short supply, too?

*(*Dr *Candy.)* They are indeed. That is quite right. I think that even without those facilities it is possible to use these drugs more wisely now than perhaps was the case 15 or so years ago. I think the proper solution to the issue being discussed here is to provide facilities for more appropriate and up-to-date treatment of these sorts of difficulties that would avoid the use of tranquillising drugs and all the problems that can flow from that.

*(*Ms *Padel.)* I think in psychiatric units the pressures on patients who are suffering from mental disorder are sometimes worsened by being locked up for 23 or 24 hours a day because they are the most difficult prisoners to allow out of their cells. The pressure then to prescribe tranquillising drugs to control the condition then becomes immense. We certainly get quite a lot of complaints that prisoners have not been given drugs they feel they need and which simply act to alleviate the pressures on them, which are certainly exacerbated by their imprisonment.

593. You recommend that prisoners should be able to keep proprietary medicines in their cells. Can we first of all clarify what proprietary medicines you mean. Do you mean letting them bring in with them when they come into prison medicines which they have been using outside or do you mean those they would be given by the prison doctor?

*(*Dr *Shaw.)* I think all I had in mind would be simple forms of cold/cough remedies, that sort of thing.

594. Which you are suggesting they may bring in from outside?

*(*Dr *Shaw.)* I had not envisaged they would bring them in from outside.

595. I wanted to clarify that. You mean those prescribed by the medical officer?

*(*Dr *Shaw.)* That is right.

596. There is the problem perhaps with drugs that might be dangerous if taken in large quantities that hoarding might be a problem or overdosing?

*(*Dr *Shaw.)* Yes, I can see that with aspirin or more obviously with paracetamol. However, there are ways round that.

[Chairman *Contd.*]

First, if you place some trust in prisoners I think they are likely to respond to that. Secondly, if the proprietary drugs you are allowed—let us take aspirin—were available as you would buy them in Boots, with 12 or 24 to a packet, I do not think there is a problem there of over-dosing. If the issue is that the prisoner would over a long period of time hoard those drugs because he wished to commit suicide, it is a question of the nature of the prison regime in general and its ability to assess those who are suicide risks. Clearly one would want to override the right of prisoners to have proprietary medicines if they were suspected of being a suicide risk.

597. There is also the question of hoarding in order to gain some advantage by making deals with drugs—trafficking in some way? That is also a hazard, is it not?

*(*Dr *Shaw.)* It is a potential hazard. I think it could be exaggerated. It is certainly true that within the prisons there is an alternative economy made up of all sorts of items and that one might be added, but if you are suggesting all prisoners should have the right to have any type of proprietary medicines, I am not sure the trade in them would be all that lucrative.

Mr Winterton

598. What about substitution? It is very easy to produce a drug or a pill from what might appear to be an ordinary aspirin or paracetamol; it could be stuffed with cannabis or heroin, you name it, which could be substituted and supplied in a foil packet that looks like aspirin or paracetamol. Do you not think this is opening up a door which could produce more problems than the solutions which I suspect you sincerely believe would be the case if the regime were liberalised?

*(*Dr *Shaw.)* I think this relates to the Chairman's initial question. I was assuming certainly that drugs would be made available from the prison dispensary rather than being brought in from the outside.

599. How could you tell if they were from the official prison medical service or brought in from outside if they were in similar containers, similar packets, similar whatever it might be, to what might be prescribed by the prison doctor?

*(*Dr *Shaw.)* Again people do endeavour to smuggle items in from the outside at the moment. Prison officers are skilled in preventing that from happening. I am not convinced that this is a real problem with which we should be faced.

Sir David Price

600. Could I address the next question to Dr Candy? In support of your argument that the Prison Medical Service should be integrated within the National Health Service you refer to the recommendation of the Royal College of Psychiatrists in 1979. In the evidence which they gave us, the Royal College appeared much less keen on this idea—this is six years later—largely, I think, because of the low priority that health authorities appear to attach to forensic psychiatry. I wonder how you react to that.

*(*Dr *Candy.)* The question of finance and resources is the key question and as regards the integration of the Prison Medical Service into the National Health Service some means would have to be found so that the Prison Medical Service did not become the Cinderella of the psychiatric service. I think there are various ways of aiming to ensure that proper financing and resources are provided for the Prison Medical Service. It may be that the recently introduced Griffiths Structure within the National Health Service might make that a lot easier than in the past. I would in a sense agree that if the problems of resources and financing of the medical service within prisons cannot be solved, there are real reasons that integration would not bring about benefit. They could be solved, but they must be solved.

601. Would there not be a natural tendency within any national health authority to give a low priority to this aspect of this work with the all the pressures from the rest of the community. There are so many other areas where the community are pressing for greater services, more facilities than those which are currently provided. The health authorities could give you their shopping list of priorities.

*(*Dr *Candy.)* That is right. Just because we identify that tendency, does not mean that we have to accept that tendency. Further to that, there would be some benefit perhaps to forensic psychiatry in general because, as far as the National Health Service is concerned, my experience—and this is local—in one sense is that it is particularly difficult to provide good training in forensic psychiatry and perhaps more generally good forensic medicine. If the prison health services were united with the National Health Service that would be

[Sir David Price *Contd.*]

fostered and there would be an influx of interest and activity.

602. Can I ask you whether it would be fair to draw a distinction between the general practice aspect of the Prison Medical Service, to which one can draw a very close parallel to general practice outside the prison walls, and the more complex psychiatric problems?

(Dr *Candy.*) Certainly. I feel there would be an advantage for the GP services within prison if the prisoners were part of general practitioners' National Health Service lists. At present I think the general form, and it maybe varies throughout the country, is that some GPs have sessional commitments to the prisons so they come in for their expected sessions and provide a service. A majority of them provide a very good service, but these patient prisoners are not on their lists, not on the National Health Service lists, and there is some divorce between the two aspects of their work which leads to a rather poor service as far as the prisoners are concerned. I have discussed some of these issues with local people within the National Health Service—the Regional General Manager, a District General Manager and a Unit General Manager—and all three of them are broadly in favour of the view that the National Health Service should look after the prison health service.

Chairman

603. Who would be responsible for the administration? Would it be the region or the special health authority?

(Dr *Candy.*) There are certainly various models. I would not like to say that I have sufficient experience and knowledge to favour one or the other. I think that it would be preferable to work out some way by which the prisons, which were located within a particular health district, were looked after by that health district, perhaps under the management of the District General Manager although I think there would be a regional base as well.

604. That would effectively be the DHSS?

(Dr *Candy.*) Ultimately.

605. But it might be difficult to organise one system for one set of prisons or different prisons in different parts of the country.

(Dr *Candy.*) There would be differences in scale. I hate to think how the Isle of Wight, which has Albany, Camp Hill and Parkhurst, would be able to cope when you think that there would be other districts with no prisons and I do feel that would be an issue. The doctors and managers, to whom I have spoken, feel it would be right and proper for prison services to come within their aegis. They have positive reasons why they are concerned with improving what they also see as a system, a structure, which runs the risk of providing, I say only the risk of providing, a second-rate service or could be thought to provide a second-rate service.

Sir David Price

606. Has the Scottish experience assisted you in coming to this conclusion?

(Dr *Candy.*) Not particularly. I have no great familiarity with the Scottish scene in this area.

607. Could we go on to Dr Whitehead? In his paper he refers on page 50 to "a significant increase in the use of physical restraints," and I would like to ask what evidence there is for this?

(Dr *Shaw.*) There are number of different types of equipment and of cells which are referred to by the prison service as "restraints". I think in that section Dr Whitehead was referring to something called the "body belt".

608. Strip cells?

(Dr *Shaw.*) There are in addition certain types of cell; special cell, protected cell and strip cell. Indeed, in one prison which we visited recently, they are known euphemistically as "quiet rooms".

Mr Winterton

609. Which one is that?

(Dr *Shaw.*) That is Parkhurst. They are all termed as "restraints". Rather like the question of drugs, the Home Office statistics are very imperfect. Certainly on the use of body belt, which is reasonably well recorded, there has been a substantial increase in its use over the last three or four years. The most frequently used form of restraint is the strip cell and there is no requirement on the Home Office to record use of the strip cells and no statistics are published. We know about the increased use of the body belt because it is clear and in writing, but if one goes on to the use of segregation cells it has to be a matter of opinion because the statistics are not accurate or not available.

Mr Kennedy

610. I know it is specific on a very broad point, but did the so-called "cages" at Porterfield Prison in Inverness come under the recording of strip cells? It is terribly specific, I know.

*(*Dr *Shaw.)* I suspect they are a category of their own, but I do not know the answer to that.

Mr Winterton

611. Bearing in mind the fact that you are now probably, within prisons, dealing with more difficult people and, not least with the policy of care in the community; the psychiatrically disturbed people are discharged into the community and they are sadly coming back into the prison system and they have a mental illness. How else would you protect these people from themselves and other people from them if you do not have a strip cell or a segregation cell in which these people can work out their fury and their temperament? It is a problem which they cannot be responsible for because they are mentally ill. How do you deal with these people?

*(*Dr *Shaw.)* I do not think we accept the premise of your question. It is our view that much more effort should be made so as to ensure that the NHS accepts its responsibility for mentally disordered offenders. One of the reasons for integration of the prison medical service within the NHS is the expectation that transfers of mentally disordered prisoners might be more acceptable to the NHS than they are at the moment.

612. But you are missing my point. I must probe you on this. If the situation is as it is, not as you would wish it to be, how would you deal with these people if they are not put in a strip cell or a segregation cell? I must ask you that question. Could I have a direct answer?

*(*Dr *Shaw.)* Yes, you could. If we look at Grendon Underwood prison—

613. And we visited it.

*(*Dr *Shaw.)* —you will know that the segregation cells are virtually never used, that psychotropic medication is almost never used either, that the number of assaults on staff and other prisoners is very low.

614. They are also very selective of those they send to Grendon Underwood?

*(*Dr *Shaw.)* They are selective. In the statement which Lord Donaldson—who has a relationship with Grendon Underwood going back 25 years—made in the House of Lords, he said that something like 70 per cent of the prisoners in Grendon Underwood have a previous history of self-mutilation or suicide attempts. That is not the case when they get to Grendon Underwood. I think there is a clear relationship between the type of prison regime which is operated, both in terms of physical conditions and what you do with prisoners when they are inside and their behaviour. Very often what is undoubtedly bizarre behaviour is a response to a bizarre environment. Again, a very clear example of that is the situation at a prison I do know in Scotland, Glenochil. There is no question that the behaviour of many of those inmates of Glenochil is a response to the conditions in which they are held.

*(*Ms *Padel.)* Can I add that when we went to Parkhurst we visited the psychiatric assessment landing, where most of the cells contain nothing but cardboard furniture and people were undergoing psychiatric assessment by being locked in these cells, which is a rather strange situation anyway. One example in the case where the silent cell was used was where somebody ran out of cigarettes the night before he was due to get his prison earnings so that he could buy more and he kept the rest of the prisoners awake all night by banging on the door. So he was put in the silent cell to prevent him keeping other prisoners awake when a simpler solution may have been to give him some cigarettes.

Mr Yeo

615. Does the Prison Reform Trust share Dr Whitehead's view that people with personality disorders are untreatable and should not be given drugs at all?

*(*Dr *Candy.)* I am not speaking on behalf of the Trust. I contributed to the written evidence but I am not necessarily representing the views the Trust has put forward. Could you repeat the question, please?

616. Yes. Do you share Dr Whitehead's view that people with personality disorders are untreatable and should not be given drugs?

*(*Dr *Candy.)* I think that personality disorders can often be helped by appropriate management. That does not necessarily include the prescription of drugs but it may do in certain cases at certain times.

617. It does not necessarily exclude it?

*(*Dr *Shaw.)* The majority of people in

Mr Yeo *Contd.*]

Grendon Underwood are considered to be suffering from personality disorders. One is hard-pressed to think of many examples within the prison system of interesting experiments which have worked. Grendon Underwood is one experiment which has worked. I think the hospital annexe in Wormwood Scrubs is another. The annexe has a very low use of drugs despite the physical conditions there. Despite the fact that the majority of prisoners are two to a cell, and slopping out and all the rest of it, they make fewer demands on the prison doctor once moved into that regime. In looking at prison medicine you have to look at the whole nature of the prison environment and what prisons are for. If all our prisons are to remain as they are—in many cases a grossly overcrowded slum where there have been increasing restrictions on the amount of time people spend out of cells as a result of closures of workshops and restrictions on education and so on—that is bound to lead to an increase in both physical and mental ill-health amongst prisoners. I do not believe we have to accept that status quo as going on forever.

Mr Winterton

618. You are speaking of mental illness rather than people with personality disorders. Your reply to my earlier question was clearly related to people with personality disorders rather than people with mental illness. How would you deal with them when they show very violent behaviour which might be a danger to themselves and inevitably, sadly, also a danger to other inmates?

(Dr Shaw.) I do not think either we or Dr Whitehead in his part of our evidence are suggesting it would always be inappropriate to use drugs. That is not our view. The concern about drugs has been their alleged overuse and their use where it is a question of control rather than of treatment. That is what is at issue.

Mr Kennedy

619. Following on from that question, you are saying basically whether that type of person is in a prison or a hospital situation at the end of the day the treatment might have to be the same?

(Dr Shaw.) Possibly, though very likely the behaviour will be different because of the differences between prisons and hospitals and what prison actually means—being locked up in a cell, restrictions on contact with their family, limited time on work and recreation and so on. That is different from a hospital situation.

(Dr Candy.) Because someone is mentally ill it does not necessarily mean their behaviour is not amenable to their environment. Altering their environment in the prison where they are is what one would naturally try to do but that is particularly difficult to do in a prison setting. I have no doubt that the best way of reducing the use of restraints and drugs in prisons is to reduce overcrowding in prisons, in other words, improve the environment.

Mr Winterton

620. So you are saying clearly—and I support you in this if this is what you are going to say—that there are people in prison today who would more properly be dealt with in hospital rather than in prison and the offence for which they are committed to prison is the result of mental illness rather than a criminal tendency?

(Dr Candy.) I am sure there are some people who fall into that category. I do not think anybody would argue with that. The problem is in deciding how many there are and it is a very big problem—a problem that would be eased by the integration of the prison health service with the national health service.

Mr Favell

621. Returning to Grendon, I think you have probably over-emphasised the success because there are two things which are very different about Grendon. One is that the staffing there is obviously a lot more generous than in most prisons. The second thing is that anyone who misbehaves is put on his bike; back into prison he goes and probably to a strip cell at the end of the day, so it is rather unfair to say that Grendon is a perfect system and deals with the whole problem?

(Dr Shaw.) I hope I did not suggest it is perfect. As regards staffing, it is more generous but it is not that out of line and it is less than in most of the long-term dispersal prisons, so one can exaggerate the success rate resulting from it. It is certainly true that Grendon does transfer out people who cannot handle the regime and without doubt that does play some part. One of the things which the Home Office has been endeavouring to do following something called the report of the Control Review Committee has been in general within the prison system to offer incentives to prisoners to behave well, and while the psycho-

[Mr Favell *Contd.*]

logy may be somewhat crude the result is certain improvements in the prison regime.

Chairman

622. It often works. It works with children and animals.

(Dr *Shaw.)* The Home Office has not drawn that analogy between prisoners and animals.

Mr Favell

623. Almost anyone is going to be upset at the prospect of a strip cell, and the Committee, who have seen many on their visits, are upset at what goes on there. Have you any statistics on how many prisoners visit a strip cell during their stay, what percentage?

(Dr *Shaw.)* As I mentioned earlier, it is impossible to tell anything about the use of strip cells because the Home Office publishes no statistics. The strip cell is the most commonly used form of restraint and we have no statistics covering its use. We have no official definition of what constitutes a strip cell.

624. Would you share the view that it is a very small percentage of the prison population that ever visits a strip cell?

(Dr *Shaw.)* I think that must be true.

625. If I could direct a question to you, Dr Candy, you proposed the involvement of local community physicians in prison management. Would you like to enlarge on that?

(Dr *Candy.)* In a sense the prison is part of the community; it is set in the community; its prison officers no doubt live within that community, and it seems appropriate to try to integrate it more fully with the community. Of course, the prison is an institution and the prisoners are detained there. Nonetheless, it seems that local prisons might well become more nearly what that name implies. There would be a real advantage in ensuring that the function of the prison medical officers in overseeing the environment within the prison—the sanitation, hygiene, kitchens (dare I say it)—should be undertaken by local community physicians who also have responsibility for such matters in the community at large. They are trained to do that sort of job and would be going into a prison that is standing in the middle of that particular health district.

Mr Winterton

626. Does that not happen already? We visited Featherstone prison last week where the actual medical cover was undertaken by a local general practitioner, who not only attended to the prisoners' medical requirements but also oversaw the hygiene, the kitchens, the lavatories and the various other public health aspects of the prison.

(Dr *Candy.)* It would to some extent be an advantage to separate out those functions. To ask a general practitioner, with the training a general practitioner has, to undertake, to do those tasks is probably not very reasonable. The particular function relating to a closed institution, where matters of hygiene, sanitation and general environment are, we hope, very important, should be undertaken by a man who has been trained to do it.

(Dr *Shaw.)* Perhaps I can add to that by saying that it would be our view, whatever view the Committee may come to as to the future of the Prison Medical Service, that there are short-term changes which can be made which might increase the outside monitoring and accountability of the prison system. One is the lifting of Crown Immunity from prisons as is proposed for hospitals. Certainly some of the details which came out of the Stanley Royd Inquiry relating to the storing together of cooked and uncooked meats are relevant to prisons. The Prison Inspectorate has been able to demonstrate that goes on within a number of prison kitchens. We would like to see environmental health officers having some locus within prisons.

627. Do you mean a statutory locus because at the moment they are consulted and very often they do go around and they do inspect, but these inspections are not necessarily by the local services or the prison services?

(Dr *Shaw.)* That is right.

Mr Favell

628. Failing full structural reform—and obviously it is clear from what you say that you would favour the Prison Medical Service going into the NHS—but, failing that, what other changes would you like to see?

(Dr *Shaw.)* I think there are a number relating to this question of monitoring and of the safeguards for prisoners as patients. I am not aware, other than for bureaucratic reasons, of any reason why prisoners should not have access to the Health Service Commissioner. It has been suggested in a slightly different area that prisons might

Mr Favell *Contd.*]

come within the remit of the Mental Health Act Commissioner and that would be another change which we would like to see. Indeed, there may be a role for the Health Advisory Service. Here I go beyond my own competence but I understand that one of the functions of the Health Advisory Service is to give advice to doctors and I see no reason why their role should not be extended to include prisons within their remit.

Mr Winterton

629. Do you feel there is anything in the view that prisoners get a better quality of medical service than the man in the street, for example, if they need a minor operation they will get it quicker than the people outside?

*(*Dr *Shaw.)* There is a paradox. There are certain aspects where prisoners may appear to be favoured. Dentistry was one area where, until recent restrictions, prisoners enjoyed ready access to dentists and treatment was free. By contrast, many people find it is difficult to find an NHS dentist especially in London. That is probably one area. Another example would be the people who sleep out rough underneath the Arches at Charing Cross. They get picked up on some petty charge and are put into Pentonville where they are fed and kept warm and their lives are extended because of going into prison. In general, I believe that the medical care which prisoners receive, and certainly the safeguards governing that care, are inferior to those on the outside. There certainly are areas where prisoners benefit and there are equally other areas where I think that they do not.

Mr Favell

630. Would either of your colleagues like to see any changes short of restructuring?

*(*Dr *Candy.)* I think in the last three years there have been improvements. I have lost such immediate contact as I had earlier with the service, but I understand it is now up to establishment. It think it is possible that the community health councils might have a role to play.

Chairman

631. How would that work?

*(*Dr *Candy.)* They are concerned with the health service provided within that particular district and there must be no reason why they should not have some concern about the health services provided within the prisons within that district.

632. To see the prisons and to see what was going on?

*(*Dr *Candy.)* Yes.

633. Do you think they would be effective or strong enough?

*(*Dr *Candy.)* Some community health councils are effective. I think it depends on the particular people who are on that body.

*(*Dr *Shaw.)* I do not want to prolong this, but can I just add that one argument against introducing a special health authority governing prisons and other secure hospitals is that it is not clear whether one would have a special CHC governing those things or what locus local CHCs would have. I see an argument for having a special health authority, particularly on the resources argument, but the question of accountability and local accountability would arise.

Sir David Price

634. Accepting that point about accountability, would it not be very nearly, in terms of the doctors who are concerned, the phoenix that would rise out of the ashes of the Prison Medical Service, in practice?

*(*Dr *Shaw.)* That is my view.

635. They have a different boss, but that is about all in terms of difference?

*(*Dr *Shaw.)* It would not represent the full-scale integration which we have argued for. I think it has to be said that the lessons of NHS reorganisation are that one does not always pick the best model the first time around.

Chairman

636. In your paper, you refer to your time on the Parole Board and you have said that on the whole more balanced and relevant reports were those written by the visiting psychiatrists than by the prison medical officers. Could you enlarge on that for us?

*(*Dr *Candy.)* Not very far. It is my impression that that was the case. There was great variation in the content, style, manner and extent of the reports which I read and I do feel that some of them went far beyond what ought to have been said, bearing in mind that the person writing that report was a doctor talking about a patient.

637. Did that apply to any particular type of person; men or women?

*(*Dr *Candy.)* I think primarily of men, but they are in the vast majority in the prison

[Chairman *Contd.*]

service in any case. Again I am very reluctant to be too particular here, but there were certain doctors who produced, I think, deplorable reports, though many of them are excellent.

Chairman: I was just intrigued to know what you meant.

Mr Winterton

638. That goes on in the ordinary National Health Service.

(Dr *Candy.)* I think that is true. I think the Mental Health Act Commission, which has recently been set up since the 1983 Act, might have a helpful role to play in solving the real problems about treatment and consent to treatment within prisons. They have been looking at that in the context of detained patients and informal patients as well. Although they have recently produced a very large report which is rather indigestible, it might be in time that they would have something valuable to say in relation to difficult questions of consent to treatment within prisons.

Chairman

639. What about reports? Would you want all reports done by outside psychiatrists? Would that be an advantage?

(Dr *Candy.)* There is a case to be made for that, for separating the reporting function from the day-to-day medical care function. There are pros and cons about this.

640. Where would you come down? Can we have a view?

(Dr *Candy.)* I would come down on separating the function of writing reports for parole and other purposes from day-to-day medical care.

Mr Favell

641. One of the "cons" for difficult cases is that you need surveillance for a considerable time before writing a report which would determine a man's life over the next 25 years.

(Dr *Candy.)* Yes.

642. And it would be difficult to write a report of that kind?

(Dr *Candy.)* I am not suggesting that the person writing the report should not discuss the matter with the prison doctor. As in all such cases he should get as much information from as many sources as possible about the person on whom he is writing the report, and he should make clear to the person to whom he writes that report what his sources of information are.

Mr Winterton

643. What about the communication of that report, following on a report, when that inmate is released? What about the communication between the prison medical service, those who deal with the inmates within an institution, and those who perhaps will take them on if they do get a general practitioner out in the sticks?

(Dr *Candy.)* I am sure there should be good communication.

644. But is there, in your view?

(Dr *Candy.)* I think it varies a lot.

645. If it is not, how do you think it can be improved?

(Dr *Candy.)* At one level I think if general practitioners who were doing most of the basic medical work in prisons had these prisoner patients on their national health service lists it would be easier to ensure that those GPs got information about the prior history of the prisoner patients.

646. Many of the people serving in the prisons do not have any chance of following them up when they leave because the people go to an area way outside the sphere of their own panel?

(Dr *Candy.)* That is right, and they register with another general practitioner anyway where they settle and that GP needs reports from the doctor who has been looking after the prisoner while he was in the hospital. I do not want to make a very big point about it but I think that this form of communication, which is important from the point of view of continuity of medical care, ought to be easier within a single, integrated service.

(Ms *Padel.)* I think in cases where there is a need for psychiatric supervision, where there is a parole licence or life licence, there is usually good communication, often organised with the help of the probation service, but there is some concern when somebody comes into prison serving less than two years and their medical records do not follow them when they enter prison. I have encountered more difficulties when people have gone into prison suffering from, for example, epilepsy or diabetes and have been on medication which stabilises their condition. When they get into prison serving 18 months, for example, their medical records have not followed them. In one case a man had to be transferred back from a training prison to a local prison hospital wing. The man was suffering severe symp-

[Mr Winterton *Contd.*]

toms because his epilepsy had become completely unstable. No records followed him. His epilepsy before had been stabilised for 20 years.

Chairman: I think that concludes our questions to you. Thank you for your help.

Memorandum submitted by MIND

1. Introduction

1.1 MIND (National Association for Mental Health) is the foremost national voluntary organisation in the mental health field. It has seven regional centres and nearly 200 local associations offering a wide variety of direct services to people in need.

1.2 MIND welcomes the initiative of the Social Services Select Committee in deciding to conduct an inquiry into the prison medical service. The prison medical service, in our view, is beset by long standing problems which have proven immune to intervention. A thorough review of its purpose, its methods, its structure and its management has been needed for some time.

1.3 MIND's submission to the Social Services Select Committee is based on the premise that prisoners are entitled to the highest quality medical care and that access to appropriate treatment should not be impeded by imprisonment.

1.4 The prison medical service cannot be viewed in isolation from the prison system as a whole. For this reason this submission begins with the context within which the prison medical service operates.

The General Context

Size and Composition of the Prison Population

1.5 The average prison population in England and Wales has continued to rise steadily from nearly 23,000 in 1957 to 43,000 in 1983. During 1985 the population has risen at an unprecedented rate reaching 48,000 in July.

1.6 In 1983, while the average prison population stood at 43,500, the highest levels of occupancy took place in March (44,700) and May (43,700). The certified normal accommodation on 30 June 1983 was 38,783.

1.7 This compared to an average prison population in 1982 of 43,700 with peaks of 44,000 and 44,500 in March and November respectively. The certified normal accommodation for 1982 was 38,570. Since 1960 average daily population has consistently outstripped certified normal accommodation.

1.8 During 1983 the average size of the remand population (those awaiting trial or convicted awaiting sentencing) was 7,300 with an annual highest figure of 8,130. The average male remand population rose by four per cent in comparison with 1982 and that of the female remand population by two per cent. Remand prisoners represent the fastest growing section of the prison population.

1.9 The peak age range for male sentenced prisoners was 17–20 and that for female sentenced prisoners 30–39.

1.10 The average female prison population rose from 1,330 in 1982 to 1,390 in 1983. The peak annual figure for 1983 was 1,470 and occurred in October. The average male population for the same period was 41,946.

1.11 The single most common offence of male sentenced prisoners was burglary while that of women was theft.

1.12 At any one time the most frequent length of sentence being served by adult male sentenced prisoners is 18 months to four years and for young male sentenced prisoners 18 months to three years. The equivalent lengths of sentences for female sentenced prisoners are 18 months to three years for adults and three to six months for young women. However the most frequent sentence imposed by the courts, for both men and women, is less than 12 months.

Cost of Imprisonment

1.13 In 1981–82 the average weekly cost per prisoner was £178. Dispersal prisons had the highest weekly cost at £370 and open prisons the lowest at £127.

European Comparison on Imprisonment

1.14 In 1984 the prison population of England and Wales was 83.3 per 100,000 total population. This compared to 171.1 in Turkey, 114 in Austria, 47.6 in Ireland and 30 in Malta.

2. The Prison Medical Service

History

2.1 As early as 1774 Parliament passed an Act Preserving the Health of Prisoners in Gaol and Preventing Gaol Distemper which required all prisons to appoint a surgeon or apothecary. But it was not until the prison system was taken over by central government in 1877 that this requirement could be enforced. It was at this time that the prison medical service first came into being.

2.2 Since its inception the prison medical service has been concerned to meet both the physical and mental health needs of prisoners. The relative importance of these two aspects of health care has been the subject of changing climates of opinion.

2.3 In 1895 the Gladstone Committee recommended that candidates for medical appointments should produce evidence of having given special attention to lunacy. By 1959 this view had become so pervasive that the prison department wanted psychiatric expertise to be available to all prisoners. But during the 1970s the much hoped for benefits from psychiatric treatment of criminality proved disappointing and the emphasis of treatment within the prison medical service swung round again to general medical care.

2.4 The creation of the NHS in 1948 provided an opportunity for the prison medical service to become part of a new national service but the chance was not taken.

2.5 In 1964 the Home Office set up an inquiry into the prison medical service and its relationship with the NHS. Integration of the two services was again rejected. Instead joint posts in forensic psychiatry between the prison department and the NHS were created. It is generally agreed that these joint posts have been a failure and are now being phased out.

Organisation

2.6 The prison medical service is part of the prison department, which in turn is part of the Home Office.

2.7 All directors of the prison medical service to date have been doctors. The director of the prison medical service sits on the Prisons Board which is operationally responsible for all the prisons in England and Wales.

Staffing

2.8 At the end of December 1983 there were 77 full-time and 96 part-time doctors in post

to staff 120 prison department establishments. Twenty full-time posts and 18 part-time posts were vacant.

2.9 Full-time doctors tend to be concentrated in large local prisons where there is a high turnover of prisoners and many court reports to be written.

2.10 Additional medical and paramedical support is provided by 120 visiting practitioners employed by the Home Office on a sessional basis. It is estimated that two-thirds of all medical work done in prisons is carried out by doctors whose principal employment is in the NHS. Visiting doctors are local general practitioners and specialists in psychiatry, venereology, surgery and gynaecology.

2.11 At the end of December 1983 843 hospital officers were in post and 148 posts were vacant. At the same time there were 161 nurses in post and 32 vacant nursing posts. Hospital officers and nurses comprise two separate services with hospital officers, predominantly men, working in men's prisons and nurses, predominantly women, working in women's prisons.

2.12 There are long standing recruitment difficulties for both doctors and hospital officers in the prison service. Competititons for full-time medical officer posts in 1983 yielded 182 applications but only 11 appointments. At the same time the 24 new hospital officers were "barely adequate to make good the loss from natural wastage and substantially short of that necessary to begin to close the ever widening gap between the number of staff in post and the number of approved posts" (Report of the Prison Department 1983). A further problem acknowledged by the prison department has been the failure to raise the proportion (currently 10%) of hospital officers with nursing qualifications.

2.13 Hospital officer training has been increased from 13 to 24 weeks and extended to include a module covering the principles of psychiatric care in a secure environment. But staff training programmes remain inadequate. Most nurses working in the prison service, for example, are qualified general nurses but have no psychiatric training. In addition, although 45 per cent of prison doctors have postgraudate psychiatric qualifications, there is no comprehensive programme of in-service training or continuing education.

Role of the Prison Doctor

2.14 Medical officers are appointed by the Home Secretary and are officers of the prison service as well as medical practitioners. The grade of medical officer is equivalent to that of Assistant Governor with an added responsibility to advise on medical matters.

2.15 All requests to see a doctor are channelled through prison officers. Prisoners have no direct access to doctors or medicines of any kind.

2.16 Prison rules place an explicit duty on medical officers to pay special attention to the mental health of prisoners and to inform the Governor of any suspicion of suicidal intent or ideation.

2.17 At the same time medical officers have a duty to certify whether or not prisoners are able to undergo restraint, solitary confinement or other punishments. They also have a responsibility to ensure that conditions of imprisonment are not injurious to health.

2.18 The largest proportion of prison doctors' time is spent in writing reports for courts, the Parole Board, the Home Office and the Governor.

2.19 All prisoners are seen by a doctor on reception. Prisoners suffering from physical or mental illness or those who may be suicidal are identified and allocated to appropriate parts of the prison. These consultations are crucial but are carried out under extreme pressure and at great speed. It is hardly surprising that significant signs and symptoms of physical or mental illness are sometimes overlooked.

2.20 There is a clear conflict of interest between the roles of personal physician and senior manager, which a prison doctor performs. The same doctor may well be treating a prisoner, commenting on his/her potential for parole and sanctioning his/her punishment.

2.21 There is no confidentiality between patient and doctor within prison. Medical notes are a part of the prison record and are used in management and allocation decisions.

2.22 In these circumstances it is hardly surprising if the lines between treatment and control are blurred and if prisoners regard doctors as, first and foremost, agents of prison management.

Recommendations

1. The prison medical service should be integrated with the National Health Service. In this way prisoners would have a choice of doctor, standards of care and treatment would be monitored more effectively and staff recruitment problems would be eased.

2. A measure towards full integration of the prison medical service and the NHS would be to separate the functions of personal care for prisoners and "medical officer of health" for the prison. In such circumstances the appropriate regional health authority would assume responsibility for the personal care of prisoners and the prison medical service would retain its "medical officer of health" role.

3. The Health Service Commissioner should be empowered to enquire into the administration of health care in prison.

4. Local community health councils should have unimpeded access to prisons and be able to take up prisoners complaints about health care within prisons.

5. The Mental Health Act Commission should be empowered to investigate psychiatric care within prisons.

6. Urgent attention should be paid to the recruitment of professionally trained and experienced medical, paramedical and nursing staff.

7. Nursing care should be provided by fully trained, qualified and experienced nurses employed by the regional health authority. Within each prison there should be a balance of nurses with general and psychiatric training.

8. All prison staff should have opportunities for in-service training, professional development and continuing education.

3. Mentally Disordered Offenders

3.1 It is very difficult to determine the numbers of mentally disordered offenders within prison. The Home Office quotes statistics which relate to the numbers of prisoners made the subject of a hospital order by the courts under section 37, and the numbers recommended for transfer under sections 47 and 48, of the Mental Health Act 1983. But these are obviously a gross very substantial under-estimate of the level of mental illness and emotional disturbance within prisons.

3.2 In 1983 766 hospital orders were made as a result of recommendations by prison medical officers. This compared to 629 in 1982.

3.3 In his book, Violence in Prisoners and Patients, Peter Scott suggests that prisons, mental hospitals and reception centres share the same habitual population and that when mental hospitals are full prisons are empty and vice versa. He reports that 60 per cent of homeless people have been in prison, 20 per cent are mentally or physically handicapped

and that 24 per cent have been in mental hospital. He also states that one-third of *habitual* prisoners have a severe mental disorder and a further 33 per cent have severely deviant personalities.

3.4 No adequate or systematic studies have been conducted on the number of mentally disordered offenders in prison but Coid has reviewed the best 11 conducted this century and concludes that:—

(a) psychosis is no more prevalent in prison than in the country as a whole. Rates of psychosis range between 1% and 6% of population.
(b) mental handicap is much more common in prison than in the community. Rates of mental handicap range between 14 per cent and 45 per cent of prison population.
(c) rates of personality disorder vary very greatly between studies. American studies show rates of 78 per cent whereas in Wakefield prison only eight per cent of prisoners were diagnosed as psychopathic.

3.5 In 1980 Professor John Gunn studied random samples of sentenced prisoners in the south-east of England and diagnosed nine per cent as neurotic, 13 per cent as alcoholic, three per cent as drug dependent, 22 per cent as personality disordered, one per cent as schizophrenic and one per cent as affective disordered.

Psychiatric Reports

3.6 In 1983 there were over 8,000 medical reports written on prisoners remanded in custody for psychiatric examination. This number rose in both 1982 and 1983.

Remands to Hospital

3.7 It appears that inadequate use is made by the courts of the provisions of the Mental Health Act 1983 which allow for remands to hospital for psychiatric reports. This results in more remands to prison custody than is desirable or necessary.

Transfers to Hospital

3.8 In 1983, 140 prisoners were recommended for transfer to psychiatric hospital under the Mental Health Act, and 110 were actually transferred. Thus at the end of the year 30 prisoners were awaiting transfer.

3.9 Regional health authorities cannot be forced to take prisoners for whom courts have made a hospital order but they may be summoned to court to explain why such a place is not available.

3.10 Transfers to psychiatric hospitals are impeded by a number of factors. Firstly the admission policies of psychiatric hospitals are such that offender patients are often not seen as suitable referrals. It is widely believed that psychiatric hospitals, as a result of more relaxed treatment regimes and greater emphasis on care in the community, have lost the ability to care for and contain difficult and dangerous patients. Secondly special hospitals are reluctant to take mentally disordered prisoners who are not treatable or who do not require the level of security operated in special hospitals. Many applications for transfer to special hospital are not successful and perhaps, as a result, the number of applications for transfer to special hospital is falling. Thirdly, the scandalous failure to develop regional secure units, despite the allocations of funds, has meant that places with medium levels of security are simply not available in many parts of the country.

Effects of Imprisonment on Mental Health

3.11 Professor John Gunn's study of sentenced prisoners in the south-east of England showed higher scores on the General Health Questionnaire for tenseness, anxiety and depression at the beginning of prison sentences. These scores fell significantly during the next six months.

3.12 Despite the absence of systematic studies into the effects on mental health of imprisonment it would seem likely that the combination of loss of liberty, separation from family and friends, the loss of one's usual social role and the dullness of prison routine is inherently extremely stressful.

3.13 In addition conditions of imprisonment, especially overcrowding, long periods of confinement in one's cell, the use of solitary confinement and the lack of opportunity for association, recreation education and exercise, have a profoundly damaging effect on mental health.

Recommendations

1. Mentally disordered offenders should not be detained in prison but have a right to treatment and care, in conditions of security if necessary, in the NHS.

2. There is an urgent need for detailed and systematic study of the numbers and treatment needs of mentally disordered offenders in prison.

3. More extensive use should be made of the remands to hospital provisions of the Mental Health Act 1983.

4. Courts should be empowered to require regional health authorities to provide treatment for mentally disordered offenders.

5. Regional secure units should be developed as an urgent priority. Admission policies should positively discriminate in favour of mentally disordered offenders in prison and those inappropriately placed in special hospitals.

6. Conditions of confinement within prison should be designed so as to minimise the detrimental effects on mental health. This should apply equally to the physical environment, to cell sharing and to opportunities for association, recreation, education and exercise. MIND supports demands for a Code of Minimum Standards of Improvement and/or a Prison Regimes Act laying down minimum statutory entitlements.

4. Psychiatric Treatments Within Prison

Drug Prescription

4.1 True levels of drug prescription within prison are very difficult to determine. The prison department statistics on drug prescription are inadequate in several important respects. Firstly there are several problems with the way in which drugs are classified. The categories of "psychotropic", "hypnotic" and "other CNS agents" are not ones used elsewhere in psychiatry and are sufficiently confusing as to be rendered virtually meaningless. "Psychotropic" drugs are defined as anti-depressants, sedatives and tranquillisers. No attempt is made to distinguish between, for example, minor and major tranquillisers nor between the very different nature of antidepressant and sedative drugs. Separating this category from "hypnotic" drugs adds to the confusion. The same drug administered at different times of day would apparently be variously called "psychotropic" or "hypnotic". Neither is any attempt made to define the nature of the drugs classified as "other CNS agents". Secondly confusion is caused by the way in which prisons are grouped together, ostensibly to protect from scrutiny the individual prescribing practices of prison doctors. As a result it is impossible to determine the rates of drug prescription in certain prisons. The size of the groupings, in some cases as large as 23, fuels suspicions that this obfuscation is deliberate.

4.2 Despite the limitations of the drug prescription statistics it is possible to identify a number of salient factors and discern certain trends. In 1983 one and a quarter million doses of "psychotropic" and "hypnotic" drugs and a further million doses of "other CNS agents" were administered to an average prison population of 43,500.

4.3 Since 1979 the same nine prisons (arranged in six groups) have occupied the top three places in the league table of drug prescribing. Six of these nine are women's prisons (Holloway, Cookham Wood, Styal, Askham Grange, Moor Court and Drake Hall) and three are men's prisons (Parkhurst, Brixton and Wakefield).

4.4 In 1983 the average dosage rates per head of prisoner population of the top seven prisons together totalled more than those of the following 19.

4.5 There is little doubt that rates of drug administration within prisons have fallen, in some cases substantially, perhaps in response to public criticism. However there are a number of prisons where drug prescription rates have increased since 1979 eg Wakefield, Dartmoor, Wormwood Scrubs, Grendon, Manchester and Leeds.

4.6 In general it seems that rates of "hypnotic" drug prescription have fallen the most. In some prisons, however, this fall has been accompanied by equivalent rises in the use of "psychotropic" drugs or "other CNS agents".

4.7 Many psychiatric drugs have powerful effects and some have unwanted or damaging side-effects. For this reason it is very important that drugs are only prescribed for the purposes of treatment, that doses are kept to minimum effective levels and that drugs are only prescribed for the minimum time necessary for effective treatment.

4.8 There are frequent allegations that psychiatric drugs are used within prisons to control deviant or undesired behaviour. In fact these allegations are so frequent that the term "the liquid cosh" has become part of the common language. However this is not a straightforward issue. Drug administration rates within prisons are high, so are sickness reports and levels of emotional disturbance and mental illness. Prisoners report being given drugs against their will or as a matter of routine but also that when drugs are requested, they are withheld. In our view drugs should not be given against the expressed wishes of the prisoner, except in order to save life, and should never be used just to aid prison management. Prison doctors have the responsibility to assess carefully the necessity for drug prescription on the basis of relief of distress and treatment of disorder.

Electro-Convulsive Treatment

4.9 We note with concern that, in the past, ECT has been administered to prisoners within prison establishments. In our view ECT, if deemed absolutely necessary, should always be administered to prisoners as out-patients in NHS hospitals.

Non-Physical Psychiatric Treatments

4.10 Prisoners' access to the full range of non-physical psychiatric treatments (for example counselling, psychotherapy, life-skills training) is currently limited, almost exclusively, to certain categories of offence or to specialised regimes (eg Grendon, Wormwood Scrubs Annexe).

4.11 In our view many prisoners may be helped to overcome personal, social psychological or emotional problems, whether pre-existing or caused through or exacerbated by imprisonment, by non-physical psychiatric treatments. Access to them, for those prisoners who choose to participate in them, should be improved throughout the prison system. Such treatments should always be carried out by professionally qualified and trained personnel.

4.12 Successive prison department annual reports place considerable emphasis on the involvement of psychologists in staff training, management and research. The value of psychologists' input to these activities is undisputed but, in our view, a balance must be struck between the demands of staff training, management and research and the use of psychologists' considerable skills and training in direct treatment with prisoners.

Consent to Treatment

4.13 It must be recognised that consent to treatment within a prison context is an extremely difficult concept. In theory prisoners not subject to the Mental Health Act 1983 have the same common law right to refuse treatment as all other citizens, including informal patients in psychiatric hospitals. In practice the prison setting imposes restrictions on the prisoner's ability to exercise his or her common law right.

4.14 In *Freeman v Home Office* Lord Justice Stephen Brown drew attention to the meaning of consent to treatment within a prison setting: "the right approach, in my judgement, is to say that where in a prison setting, a doctor has the power to influence a prisoner's situation and prospects, a court must be alive to the risk that what may appear on the face of it to be a real consent is in fact not so".

4.15 The difficulties of obtaining real consent to treatment within prison arise from the position of the prison doctor as a medical practitioner and a senior manager in the prison system. Very often the same doctor will treat a prisoner as his/her personal physician, will make recommendatons for transfer or release and will certify him/her as fit (or not) for punishment (see section 3).

4.16 In addition medical notes are not confidential, they form part of the prisoner's records and are used in taking management, transfer and parole decisions.

4.17 Prisoners report that refusing medication is often classed as a breach of discipline and incurs the usual prison punishments. An ex-Holloway prisoner reported this incident and its consequences, "As soon as the sister gave me my medicine I spat it out into my tea mug. I was caught and put on report. The next day I saw the deputy governor and I was given loss of pay and privileges—so I never refused again".

4.18 In our view it is crucial for prisoners and staff alike that strenuous efforts are made to obtain real and effective consent for all treatments. Coercion and threat should be avoided at all costs and the prisoner given all relevant information to enable him/her to give an informed consent.

Specialised Regimes

4.19 We note with interest the specialised regimes, at Grendon and the Annexe, Wormwood Scrubs in England and at the Barlinnie Special Unit in Scotland, which operate the principles of a therapeutic community within prison settings.

4.20 Despite the difficulties encountered in introducing this approach into the prison system it is, in our view, a positive and progressive step. Even if it is difficult to measure success in recidivism rates or in improvement in individual prisoner pathology, such regimes offer rare opportunities within the prison system for personal development and learning new skills. They also offer a less damaging and more humane form of containment.

Recommendations

1. Psychiatric drugs should only be prescribed for the purposes of treatment of disorder or relief of distress, they should never be used solely to aid prison management.

2. The Home Office should publish more detailed statistics on drug prescription rates.

3. Drugs should not be administered against the expressed wishes of a prisoner except in order to save life.

4. Strenuous efforts should be made to obtain real and informed consent to treatment. Coercion and threat should not be used to obtain compliance.

5. Drugs should be prescribed in minimum effective doses and for the minimum period necessary for effective treatment.

6. Prisoners should be given full information on the purposes, methods, hazards and possible side-effects of all treatments offered to them.

7. ECT should only be administered to prisoners after very careful professional consideration, as out-patients in NHS hospitals.

8. Non-physical psychiatric treatments like counselling, or psychotherapy, should be made much more widely available to prisoners who choose to participate in them.

9. Specialised regimes, like Grendon and Wormwood Scrubs Annexe, based on therapeutic community principles should be extended to other parts of the prison system.

5. Suicides in Prison

Statistics

5.1 The rate of suicide within prisons has remained fairly constant since 1959, varying between 0.3 and 0.5 per 1,000 average prison population. However, the prison suicide rate compared to that of the country as a whole is extremely high. In England and Wales in 1982 2,781 out of 49.3 million inhabitants killed themselves (*5.6 per 100,000*) compared to 17 prisoners from an average prison population of 44,000 (*38.6 per 100,000*).

5.2 In 1984 coroners courts returned 23 suicide verdicts, two verdicts of misadventure, three open verdicts and 30 of natural causes on deaths in prison. A further three inquests were still to report. All deaths by suicide were by hanging, five took place in Brixton and two each took place in Parkhurst, Norwich and Exeter prisons.

5.3 In addition to suicides, in 1982 243 prisoners injured themselves with apparent suicidal intent.

5.4 The suicide rate is much higher in remand centres and local prisons than in open or dispersal prisons. Particularly "at risk" are remand prisoners, those who are psychiatrically disturbed and lifers. Prisoners facing sentences of 18 months or longer, according to research evidence, are eight times more likely to kill themselves than those with shorter sentences. Suicide usually takes place in the first month of a prison sentence.

5.5 The experience and circumstances of imprisonment are inherently stressful. In addition there are regimes and procedures in prisons that might be expected to impose extra stress on those subjected to them e.g. solitary confinement, Rule 43, and frequent, unnotified moves. All of these reduce reassuring social contacts or product a degree of sensory deprivation. There have been to date no systematic studies by either psychiatrists or psychologists on the effects of these conditions on mental health but common sense would suggest them to be detrimental.

5.6 The key features of the prison department instructions on the prevention of suicide have been the "F" marking system and "special watch" procedures. Files of prisoners considered to be suicide risks are marked with an "F" to alert all staff to the possibility of suicide. Prisoners are either moved to the prison hospital or kept under observation at 15 minute intervals.

5.7 In 1984 HM Chief Inspector of Prisons conducted a study into the adequacy of suicide prevention techniques within prisons and found:—

(a) In some establishments well over 10 per cent of prisoners' files were "F" marked.
(b) Often the circumstances in which the marking had been applied were not clearly stated. This made it difficult for staff to know how seriously to take the implied warning.

(c) There were discrepancies between prisons, some establishments being freer with "F" marking than others. At one local prison the "F" mark was applied when the police advised that a prisoner might have suicidal tendencies but in few other circumstances.
(d) "F" marks sometimes not transferred from old files to current files, and that sometimes they were not stamped on the front covers of files despite significant entries inside (eg previous suicide attempts).
(e) The prison staff placed little reliance on the pertinent circular instructions and standing orders and in fact had little knowledge of their content.
(f) The demands made by prisoners of officers patrolling at night may well prevent them returning to a particular cell every 15 minutes, and checks of this frequency are really only practicable where a prisoner is held overnight in hospital or on a suitably staffed hospital landing.
(g) Even the most seriously disturbed prisoner can deduce enough of a pattern in the rounds of his guards to act on his suicidal resolves if he has the means to do so. Surveillance is likely to be ineffective unless it is continuous or randomised.

5.8 There are additional difficulties not commented upon by the prison inspectorate. The first concerns emergency access to prisoners' cells. If an officer patrolling at night finds a prisoner hanging, or even on fire, s/he cannot in many cases get into the cell without first collecting the key from another officer or summoning assistance. This leads to serious though avoidable delays in appropriate treatment and may increase the proportion of fatal suicide attempts.

5.9 The second problem overlooked by the prison inspectorate is the way in which placing too great an emphasis on the physical aspects of prevention can reinforce suicidal ideation and behaviour. Stripped, padded or special cells may be used for prisoners who are thought to be at risk of harming themselves. In such circumstances, prisoners are stripped, given a canvas gown and all objects which might be used for self-harm are removed. Such an environment is stimulus deprived, prevents basic human contact and removes small personal articles which enable a person to keep a hold on reality. This must add to feelings of isolation and despair.

5.10 Recognition of these, and other, difficulties has led the prison department to recommend that "F" marking be abandoned in favour of a new "check list" system under the discretion of the prison doctor. On its own this is unlikely to be more effective than the existing system. Closer attention should be paid to the need to prevent the development of suicidal ideas and intentions. This may be done by providing opportunities for prisoners, where they wish, to participate in counselling or to discuss problems, in confidence, with appropriately skilled and qualified staff.

Case Histories

Jim Heather-Hayes

"Hanging from the rafters, who do you see? You might see God but you don't see me. Corpse don't care if it's kicked in the head. You could've been alive but you're dead, dead, dead."

Those lines come from a poem by Jim Heather-Hayes, an 18-year-old prisoner at Ashford Remand Centre. He sent it in a letter to his mother. It was read by the prison censor but, though it continues in this vein for some 30 lines, the clear warning it contained was ignored and Jim hanged himself. The evidence at the inquest indicated that the Governor and Medical Officer had also ignored several of the Prison Department Standing Orders for the prevention of suicide, and the jury brought in a verdict of "lack of care". OPENMIND

Richard Campbell

Richard Campbell, an 18-year-old born in Britain of Jamaican parents, appeared in Camberwell Magistrates' Court on 3 March 1980 charged with attempted burglary and he

was remanded in custody to Lewes Prison. A week later he reappeared in court and was remanded to Ashford Remand Centre for medical reports; doubts about his mental state seemed to have arisen because of his Rastafarian language and beliefs.

Campbell started refusing food but not fluids the day that he arrived at Ashford, and he seems quickly to have become thoroughly miserable in the dismal surroundings. On 19 March he was seen by his probation officer, who scarcely recognised him. The prison doctors decided that he was a highly disturbed schizophrenic, and this diagnosis was confirmed by one of the consultant psychiatrists who regularly visited the centre. On 21 March Campbell collapsed and was taken to Ashford General Hospital, from where he was transferred to a mental hospital and seen by the duty registrar. The junior psychiatrist found him mentally normal but noticed how weak and dehydrated he was and offered to admit him for observation. He would not, however, allow a prison officer to stay with Campbell, and so the remand centre authorities took the prisoner back to the centre.

By the 26 March Campbell has lost more weight, and an attempt was made to have him admitted to another hospital under the Mental Health Act. The psychiatric registrar thought him too physically ill for the psychiatric unit but offered admittance to a medical ward, which the prison authorities refused. Back at the remand centre the prison doctors began to force feed Campbell with milk and Complan. He gained 24lb during the next four days, but on the morning of 31 March he was found dead in his cell.

At the inquest held on 8 May the pathologist gave evidence that Campbell had died from "dehydration due to schizophrenia". The jury returned a verdict of "death by self-neglect" and added a rider criticising the lack of adequate medical staff and facilities at the remand centre.

Campbell's family were unhappy with this verdict and arranged for the Battersea and Wandsworth Trade Council to hold a public inquiry. Many individuals and groups, but not the Home Office, gave evidence to this two day inquiry, which concluded: (a) that there had been no good evidence that Campbell was schizophrenic (b) that he had been failed by the legal profession, by the probation service, and by the authorities at Ashford Remand Centre; and (c) that he died "because of the negligence of the authorities". British Medical Journal

Recommendations

1. Existing suicide prevention techniques are clearly inadequate. However the Prison Department's proposals for change are unlikely to be successful unless there is a greater emphasis on helping prisoners to cope with problems and preventing the build up of suicidal ideas and intentions.

2. All prison staff should be trained to recognise and offer support to suicidal prisoners. In addition specialist counselling or psychotherapy services should be available to those suicidal prisoners who wish to use them.

3. It must be recognised that conditions of confinement may foster or exacerbate suicidal ideation and behaviour. General preventative measures such as improvements to prison regimes are as important as individual prevention.

4. Suicide prevention techniques which involve removing prisoners to stripped, padded or special cells may reinforce suicidal behaviour and should be avoided.

6. Women in Prison

Size and Composition of the Women's Prison Population

6.1 The average women's prison population has risen progressively from 841 in 1965 to 1,473 in 1984 with a peak figure of 1,516 in 1980. The 1984 average prison population of

1,473 represented a five per cent rise on the previous year. In England and Wales, on any one day, women constitute three per cent of the prison population.

6.2 In 1983 the peak age range for sentenced women prisoners was 30–39 and the single most common offence was theft. At any one time the most frequent length of sentence was six to 12 months.

6.3 One research study showed that among women remanded into custody 15 per cent had a major physical health problem, 20 per cent a major mental health problem, 21 per cent had a history of attempted suicide, 13 per cent were pregnant and nine per cent had venereal disease. Among sentenced women 21 per cent had a major physical health problem and 15 per cent a major mental health problem.

Discrimination

6.4 It is generally considered that in several important aspects women are treated more harshly by the criminal justice system than men. Discrimination is shown in the following ways:—

(a) *Remand*
Remand prisoners form a higher proportion of the population in women's prisons than that in male establishments. Only one-third of women remand prisoners subsequently receive a custodial sentence compared to over half of men.

(b) *Distance from home*
There are only 11 women's prisons in England and Wales and it is therefore inevitable that women prisoners will, on average, be imprisoned far further from family and friends than is the case for men. It is also argued that the disruption in family and social networks caused by the distance between the prison and the prisoner's usual home is more painful for women than it is for men. During imprisonment women are powerless to cope with their problems and are rendered extremely anxious by the often worsening domestic circumstances which their imprisonment brings about.

(c) *First-time offenders*
Women's prisons contain a higher proportion of first-time offenders than men's prisons. The first experience of imprisonment is inherently very stressful and this is especially so for women. Women prisoners report that the absence of a well developed female criminal sub-culture within prisons makes adaption to imprisonment harder. Women are left to struggle with the process of adjustment alone.

(d) *Gender stereotyping*
In a recent article, Law Psychiatry and Womens Imprisonment—A Sociological View, Pat Carlen argues that women are sent to prison because of their domestic circumstances, the failure of the non-penal health and welfare systems or their failure to comply with socially conditioned female gender stereotype requirements. Research confirms that women who are homeless, who are single or separated, whose children are in care, or who have drink or drug related problems are more likely to go to prison than are women offenders living more conventional lives.

Psychiatric Treatment

6.5 In the mid 1970s the medical model of female criminality was at its height. John Camp, writing at the time said "conventional prisons are unnecessary for the vast majority of women. Their offences are due mainly to personality disorders which will respond to psychiatric treatment" (Holloway Prison: The place and the people, 1974). Since that time the climate of opinion has changed, largely in response to the apparent ineffectiveness of psychiatric intervention to cure female criminality. At present women's prison regimes seem to operate on an uneasy mixture of control, treatment and training.

6.6 There are consistently higher rates of psychotropic drug prescription per head of prisoner population in women's prisons than in men's (see section 4). This, of course,

mirrors psychotropic drug prescription rates outside prison. Within women's prisons levels of drug prescription are usually attributed to high levels of personal disturbance shown by women prisoners. But it is equally likely that women are more able to ask for, or more likely to be given, psychotropic drugs to deal with the tensions and anxieties of imprisonment.

6.7 Women prisoners have limited access to psychotherapy, counselling or other non-physical psychiatric treatments. Together with the relative isolation of women prisoners from one another this results in a total absence of opportunity to discuss problems or share support. In turn this may lead to a build up of individual and collective tension within women's prisons.

6.8 One particular major focus for concern is the unit in Holloway for severely disturbed women, C1.

Education and Training

6.9 In prison, women who have never had, and maybe never wanted, a house and family are taught domestic skills. Women who have children are separated from them and made to feel guilty about that separation. Women who have already rejected conventional female roles are expected and encouraged to "be feminine". This should not be the case, education and training within prison should be explicitly related to women's expressed wishes, aspirations and chosen, or wanted, lifestyles.

Recommendations

1. Every effort must be made to prevent discrimination against women by the criminal justice system. In particular, the use of remands in custody for women awaiting trial or sentence should be reduced. Far too many women are remanded into custody for psychiatric reports who could be granted bail or, if necessary, remanded to hospital.

2. Urgent action must be taken to rectify the many problems associated with the C1 unit in Holloway prison.

3. Treatment, education and training in prison should be related to women's expressed wishes, aspirations and chosen, or wanted, lifestyles.

Examination of Witnesses

Ms Christine Shaw, Assistant Director (Publicity), Mr William Bingley, Legal Director, and Mrs Audrey Peckham, Author of "A Woman in Custody", MIND, called in and examined.

Chairman

647. Good afternoon, would you like to introduce yourselves?

(Ms Shaw.) My name is Christine Shaw and I am MIND's Assistant Director of Publicity, Mr Bingley is MIND's Legal Director and Mrs Peckham is a former head teacher, an author and an ex-prisoner with direct experience of psychiatric treatment in prison.

Chairman: We want to put some questions to you arising out of the evidence you have submitted to us.

Mr Kennedy

648. Can we start with psychotropic drugs. You say they should only be prescribed for the purpose of treatment of disorder or the alleviation of distress?

(Ms Shaw.) Yes.

649. Can I begin by asking you what is your definition of the difference between the two or do you not agree the dividing line between those two categories is extremely indistinct?

(Ms Shaw.) I think there are areas in

[Chairman *Contd.*]

which psychiatric disturbance blends into mental illness and vice-versa. There are definitions of mental illness which can be used for operational purposes and we would say that the use of drugs has a legitimate role in the treatment of psychiatric illness and the alleviation of symptoms of psychiatric disturbance in both areas.

650. I am not sure that clarifies in my mind exactly what you mean when you talk about the distinction.

*(*Ms *Shaw.)* I think what I am saying partly is that it is difficult to make clear distinctions and I think that is recognised both within and outside the prison service.

651. For example, do you think it would be justified to give tranquilisers to a frenzied patient likely to hurt him- or herself?

*(*Ms *Shaw.)* It depends so much on the individual circumstances. If you are saying for the allevation of the symptoms of schizophrenia, of depression, of anxiety, there is a role for the use of drugs in those conditions, certainly. What we would not be happy with—and I think there is perhaps quite a wide consensus on this point—is the use of drugs in the absence of any symptoms of mental illness or distress.

Mr Winterton

652. Could you actually document, though, many cases currently? I am not talking about the past where drugs have been given for the reasons which you deplore rather than the reasons which Mr Kennedy has just put to you and with which you appear to concur?

*(*Ms *Shaw.)* I think it is difficult to document cases. Perhaps Mrs Peckham would wish to comment, but there is a widespread opinion that there are circumstances within a prison where drugs are used in the absence of symptoms of mental illness. Certainly we have examples of prisoners coming to us and saying both things. This is why the whole area is so difficult. There are contradictory stories. Some prisoners will say drugs are used as a matter of routine: other prisoners will say it is extremely difficult to get treatment for distress or the symptoms of their illness.

653. But if you come forward with evidence saying there is an overprescription and that people who do not really merit medication are getting it, I do feel it is up to you to give chapter and verse to this Committee to enable us to make a decision as to whether that is the case or not. Would you not agree with that?

*(*Ms *Shaw.)* I agree absolutely but I do not think we are saying necessarily there is an overprescription. What we are saying is that rates of drug use within prison are high. We are very pleased to note that they are falling; we applaud that for obvious reasons. We are, however, saying that given the nature of some psychotropic drugs and their potential for hazard and the way in which they seem to have side-effects, we would favour their use with caution and close monitoring of the side-effects—the responsible use of them within prison. We are not suggesting otherwise.

Mr Kennedy

654. When you say you welcome the falling instances of this taking place, do you mean in the past they have been used wrongly or used for control purposes as opposed to more proper medical use?

*(*Ms *Shaw.)* I do not think it is possible to say. Drug rates have been very high in prisons and so have rates of psychiatric disturbance. This is why in our evidence we have not come down with a hard and fast judgment on this issue because we find it difficult to distinguish the evidence. This leads us to believe we would like to know much more in general about the numbers of mentally ill people in prison but also in particular about the way in which drugs are used in prison.

655. But should mentally ill people be there at all?

*(*Ms *Shaw.)* Our view is that the most appropriate response to mental illness and offence, where the two things are linked together, is treatment within the health service.

656. You say at 2.15 of your evidence that all requests to see a doctor are channelled through prison officers. What reason have you to believe, or have you any reason to believe, as your evidence suggests, that prisoners are being prevented from seeing the medical officer when they want to?

*(*Mrs *Peckham.)* I can only say—and it is your decision whether you believe me or not because obviously this cannot be documented—that during the time I spent in custody, which was eight months, there were many occasions on which people asked to see the doctor and were refused. One has first to get through the barrier of

[Mr Kennedy *Contd.*]

the prison officer. The most outstanding case of this, I submit—and it is documented—is that of Sarah Hewer, who died in Pucklechurch in January of last year. She had repeatedly asked to see the doctor and her request had been turned down—not on that occasion by a prison officer, because the hospital wing at Pucklechurch is not staffed by prison officers, but by a member of the nursing staff on the hospital wing at Pucklechurch.

Chairman

657. Why was she refused? Is there any evidence about that?

*(*Mrs *Peckham.)* The only evidence we have there is the evidence given to the inquest by the officer who refused permission, which was that she had seen the doctor previously and did not need to see the doctor again.

658. That was the nurse's judgment?

*(*Mrs *Peckham.)* Yes.

Mr Winterton

659. Could you indicate to the Committee what this lady died of? It would, I think, be helpful.

*(*Mrs *Peckham.)* That was very difficult. The inquest came to the conclusion it was death by natural causes. The only damage that they were able to find—forgive me, I have no medical knowledge—was a scarring of the heart, and having been asked whether, in medical opinion, acute respiratory distress for some hours could produce this kind of effect, the answer was yes. There is no doubt, by documented evidence to the inquest, that Sarah Hewer was suffering from acute respiratory distress for several hours before her death. That is all, I am afraid, I can say as a layman.

Mr Kennedy

660. In your memorandum you said that while you were in Pucklechurch, you had an initial consultation with the psychiatrist and then you asked to see him again repeatedly and those requests were denied. What reasons were given for that?

*(*Mrs *Peckham.)* My requests were repeatedly refused and no reason was given. I asked why not and I was then told that the psychiatrist would not see me. You do not request to see him and gain automatic access to him; it is *his* decision. As it is in prison, it is the doctors' decision as to whether or not they see someone who requests to see them.

Mr Winterton: Does that not apply also to doctors elsewhere? If you are not a young man or person out on remand, you might also have great difficulty in gaining access to a consultant. Some people even complain that they have problems in getting through the doctor's receptionist.

Chairman

661. Did you ask the prison medical officer if you could see the psychiatrist because the prison medical officer is not the psychiatrist?

*(*Mrs *Peckham.)* Yes, I did.

662. You asked him?

*(*Mrs *Peckham.)* I did. If we are talking about Styal Prison, when I went there I had my initial interview with the doctor. The Judge, in fact, had said that I should receive psychiatric treatment and I was told that I could not see the psychiatrist.

Mr Winterton

663. Could you answer the question which I put as regards the experience that people who are not necessarily on remand or inmates of a prison might well experience, in ordinary life, that it is quite difficult to get an appointment with a consultant psychiatrist or with any consultant if you cannot get through the receptionist at the doctor's surgery?

*(*Mrs *Peckham.)* I think that if ever I needed to see the psychiatrist, I agree it might take longer that it should, but I would eventually see the psychiatrist, as indeed I did outside through my GP and the fact that it is difficult outside does not make it any easier for people inside.

Sir David Price

664. In your own case if you were refused, was it not possible, given the Judge's comments, in the normal way through the Governor or were you not entitled to a right of audience with the Governor or Deputy Governor if it had been put down, as you say, in your memorandum that you should have psychiatric aid while in prison? Surely if you were not getting it you were perfectly entitled to complain to the Governor?

*(*Mrs *Peckham.)* I could have done, yes, but how long this process might have taken is another matter. I had my solicitor's advice that, given the fact that I would probably only be in Styal for three months and given the psychiatric treatment I might

[Sir David Price *Contd.*]

receive, if any, it was better to wait until I was outside.

Mr Kennedy

665. Given your own experience of people who have made a request of that type and not had their requests allowed, is the most recurrent reason given no reason at all and those requests are simply not allowed and there is no proper explanation given, no adequate explanation given as to why that should be the decision?

*(*Mrs *Peckham.)* In the majority of cases prison officers do not have to give explanations to prisoners. They can refuse to give an explanation or they can refuse the requests without explanation and sometimes the explanations are along the lines, "It is not necessary. You saw the doctor yesterday".

Mr Winterton

66. You do not have to answer this question if you do not wish to, but are you prepared to tell the Committee why you were actually committed to prison?

*(*Mrs *Peckham.)* Yes, I am perfectly prepared to tell the Committee why I was arrested and why I was committed to prison. I would like to point out that of the eight months, five months were spent on remand while I was waiting for trial and three months were actually spent serving my prison sentence. I was suffering from severe mental, nervous and emotional problems, as a result of which I was charged with a serious crime. I was charged with incitement to murder. I have pleaded innocence to that charge for which I was committed. I was arrested and after that interminably long time one has to wait on remand, I was eventually tried and convicted. The fact that I received for that offence effectively three months in prison, I think, is a demonstration of the Judge's attitude to me. That offence of incitement to murder can, in fact, carry life.

Chairman

667. Can I put two points which arise out of your evidence? You say that nursing care in prisons should be provided by nurses employed by the Regional Health Authority. How would you deal with the question of pay of those nurses? Would you give them slightly higher pay for doing that work? If you do not suggest that, how would you attract them and if you do suggest that, would that not create problems, pay differentials, with the nurses who remain outside?

*(*Ms *Shaw.)* I think that is already a problem. I understand that a number of bodies who have given evidence to you understand that the lack of parity as regards pay and conditions of service between the Prison Medical Service and the National Health Service is one reason why recruitment has proved historically to be a problem. Our proposal for providing nursing care which is paid for by the health authority is to be seen in the context that we would be recommending integration of the two services. Therefore, all health care in prison would be provided by the Health Service so, in fact, you would not be running two separate services.

668. So there would not be pay differentials because all nurses would be employed by the Health Service?

*(*Ms *Shaw.)* No, because, as you say, they would be employed by the health authority.

669. You referred to a book by Peter Scott on page 5, "Violence in Prisoners and Patients". Is that the actual title of the book because I think it is not known?

*(*Ms *Shaw.)* To the best of my knowledge, that was referred to in the material which I was using to compile my evidence under that title, yes.

Mr Galley

670. Could I ask you to go back to the question of requesting to see a doctor or a specialist? If there is no vetting, is it not possible for the system to be abused and a lot of people to waste the doctors' time. Have you any suggestions to put forward to solve it? Would it solve it if the matter was documented when the request was declined or there had to be a written response to that request and then it could be investigated at a later state? Would that be a possible solution?

*(*Mrs *Peckham.)* In answer to the first part of the question, I would like to make three points about that. In fact, when people are in prison they have no reason to malinger. It is not to their advantage to be given sick leave or time off work. This is for two very good reasons. In prison one of the important things is tobacco and the money you need to buy that tobacco. If you miss work, you miss your pay. I have known many cases of people who, when being punished, have asked for loss of remission rather than the loss of pay. Pay and the tobacco it buys are of overwhelming importance. No

[Mr Galley *Contd.*]

one would see the doctor during work. Secondly, you cannot sit up in an armchair watching the television by the fire; if you are off work in prison, you are locked up and in prison your one desire is to escape from being locked up and loss of work is not. It is not as if you have things to do by which you could at least semi-usefully occupy your time. I am aware that the consultation rate in prison is higher than outside and this is because if prisoners are feeling slightly unwell, they have not got the option. We can take an aspirin or stay in bed, but they have to see the doctor or they have to get up.

671. You were suggesting earlier that the mentally ill should be treated within the health service and you do make in your evidence a specific recommendation that courts should be empowered to require regional health authorities to commit people to hospital rather than to prison when they are mentally disordered. How would you see that working in practice?

*(*Mr *Bingley.)* I think this is a suggestion which has been rehearsed before, certainly in the passage of the Mental Health Bill in 1983, and I am aware that there are some difficulties about it. We are faced with a situation where provision for the sorts of people we are talking about within the NHS is unsatisfactorily scarce. The basis of our argument for giving this particular power to the Secretary of State, or whoever, to direct that somebody should be received into a hospital is that if that power existed health authorities would actually follow it up by being rather more active in providing the resources that are necessary. Such a power does exist in relation to an admittedly very small group of people who are sentenced under the Criminal Insanity Act, but I have never known the power the Secretary of State possesses there to direct the placement of such people in hospitals actually creating a very great problem. I can see some arguments against this particular proposition that basically the treating doctor has to be willing to accept a patient, otherwise he will feel unable to help that individual, but I think it should be recalled that before any such order is made the court will have to have before it at least two medical recommendations in the case of a hospital order saying that the person falls within the category of the Mental Health Act and actually needs treatment. Our basic fear is that under the current arrangements a large number of people are going to miss out because the development of these sorts of services is not very high on the list of priorities.

672. Would we have definition problems? We were talking about this earlier on, how one defines the mentally ill. Are the definitions within the mental health legislation sufficient?

*(*Mr *Bingley.)* Taking mental illness, for instance, the Mental Health Act essentially does not offer a definition. The furthest the law has got in a particular case is to say that anybody who appeared to be mentally ill to the reasonable man must be mentally ill.

673. I would not say that sort of thing in this place!

*(*Mr *Bingley.)* The Mental Health Act leaves the definition to a great extent to the professionals, and in a sense the courts say: "If professional opinion is satisfied that this person falls within this admittedly extremely broad, undefined definition, on the whole we will be satisfied as well." So I think definitional problems have always existed and I am not sure that proposing, for instance, that the regional health authority might have the power to direct that somebody be accepted into a national health facility is going to make this problem any worse. We have always had to cope with it.

674. When you say "national health facility" presumably you are talking about regional secure units?

*(*Mr *Bingley.)* Yes. The NHS offers a range, from secure hospitals at the top to rather more limited facilities which have been more or less in existence for a number of years within ordinary hospitals. But the range we are talking about is the regional secure units, the interim secure units and medium secure units.

675. So you would not be interested in somebody being committed to Grendon?

*(*Mr *Bingley.)* I think it may be appropriate in some cases. It depends on the case in question. It may be wholly inappropriate in other cases. It is undoubtedly true that we need a greater range of secure provision. As you know, the regional secure unit development is very far behind.

676. But is it now catching up?

*(*Mr *Bingley.)* It is, but it is also fair to say that regional secure units have been seen as the answer to a wide range of problems when they will not be.

677. Is there not a danger that regional

[Mr Galley *Contd.*]

secure units might become overcrowded if we adopt this policy? Is that a possible corollary?

*(*Mr *Bingley.)* That is certainly right. They could become overcrowded. It is a problem special hospitals have suffered in the past, but in a sense I think one is arguing that if such a power existed one would hope the obligations on the health authorities to accept such people would lead to greater priority being given to the development of these sorts of services. However, I think RSUs are only one small part of the answer.

Chairman

678. How would you persuade or direct the doctor to treat the patient if you thought the patient was not really treatable? What would be the mechanics of getting that sort of transfer done?

*(*Mr *Bingley.)* That is an extremely difficult question to answer.

679. You are putting it forward as an alternative to what happens now. We want to know if that is a viable proposal. How would it work?

*(*Mr *Bingley.)* It should be recalled that before the court felt itself able to make such an order it would have to have before it sufficient evidence from two doctors that the person actually fell within the criteria required by the Mental Health Act.

680. Which doctors? Prison doctors?

*(*Mr *Bingley.)* It could be prison doctors; it could be special hospitals may well be suitable or the particular facilities which may be most suitable for the person concerned.

681. If the special hospital doctor said that a person was not treatable, or he may have said it because he did not want to accept him in his hospital, how would you deal with the problem?

*(*Mr *Bingley.)* If the individual was not treatable the court would not be in a position to send him or her to hospital.

682. I am talking about a conflict of view between the court and the receiving doctor in the special hospital, the one who would have to take him. He would have to give his opinion, would he not?

*(*Mr *Bingley.)* He would be asked to give his opinion.

683. And if he said he did not want to take that patient for reasons better known to himself outside the medical reasons, how would you deal with it then?

*(*Mr *Bingley.)* I think it would be impossible to force him to accept him. It may be one would have to look at whether there were alternatives, explore alternatives to sending him to that particular facility.

684. Send him to another prison, you mean?

*(*Mr *Bingley.)* No, some other sort of hospital facility may well be appropriate. One would have to explore that.

Mr Winterton

685. Do you think a psychiatric hospital consultant or doctor has the right to refuse to admit to a psychiatric hospital somebody who is clearly mentaly ill and that could well have been the cause of the offence which he committed, purely on the grounds that our Chairman has put forward, that he is untreatable? Do you not believe there is a duty upon the health service to provide sanctuary or refuge for people who are mentally ill if that is the best form of treatment for them, irrespective of whether they are treatable or not?

*(*Mr *Bingley.)* The view I would take is that if an individual is untreatable a hospital is probably not a very appropriate place to detain him or keep him.

686. Let us take the example of mental illness. Where would you deal with a schizophrenic who had committed an offence because of his or her mental illness? Where would you accommodate that person? How would you treat that person, irrespective of the fact that perhaps ultimately he is untreatable, i.e. his schizophrenia cannot be cured?

*(*Mr *Bingley.)* I would slightly question the premise on which you ask the question. I do not think schizophrenia is untreatable. We are not in the business of talking about curing it.

687. Sorry, yes, I mean curing rather than treating.

*(*Mr *Bingley.)* I do not think that it is appropriate to refuse to accept somebody into a psychiatric hospital because you cannot cure him, because I think that in many ways that is not what psychiatry is about.

Mr Winterton *Contd.*]

Sir David Price

688. Is there not really a distinction between attempting to cure somebody and giving him asylum and treatment?

*(*Mr *Bingley.)* Yes.

689. I am not only talking of people who are the wrong side of the law but one knows throughout the whole of society there are cases of people who require asylum in the proper technical sense of the word, not the abused sense of the word, and you have a share of those in prison?

*(*Mr *Bingley.)* The provision of asylum is a perfectly proper objective. I would not say that you need actually to have large mental hospitals to provide that. Asylum is a proper objective for a health service.

690. But amongst the prison population you would have some people who fit into that category, just as there are in the population outside prison?

*(*Mr *Bingley.)* That may well be right, yes.

691. And some of your problems that we are dealing with here of the cases you may have in mind are the ones who, if they were not in prison, would fall logically into the category requiring asylum. What we are getting round to in this exchange of questions is that the system does not really provide for that at the moment?

*(*Mr *Bingley.)* I think that is absolutely right. There is current argument that emptying the hospitals fills up the prisons and vice-versa and there is no direct evidence that that is actually the case. I would agree with Paul Bowden's evidence at a previous sitting of this Committee. I suspect one of the major causes for the group of people we are talking about is the loss of suitable accommodation in the community, common lodging houses, etc. It may well be if you are talking about a particular group of people you are not only taking into consideration the possibility of their going to a hospital but the provision of other support within the community of an adequate sort. I would endorse the recommendations of this Committee in relation to community care.

Chairman

692. If we reached an *impasse*, then would the Court be able to direct someone to us? Do you wish them to be able to do that?

*(*Mr *Bingley.)* That is our basic position, but until they have the power, we are not going to get adequate resources.

Chairman: We are trying to find out what recommendations you would wish the Committee to make at the end of the day.

Mr Favell

693. This is an interesting assault on liberty because I, as a practising solicitor, have found that many of my clients have found that the last thing they wanted to do is to go to a secure hospital. 99 out of 100 would still prefer to go to prison rather than to a secure hospital because at least they would then know when they were going to be free to go back into society. There is an interesting side to this coin. Would you agree with that first of all?

*(*Mr *Bingley.)* Yes, I agree that is a problem.

694. We are treading into completely new territory here. The other thing I wanted to ask you about is this: is it your own experience that it is very difficult to find places in secure hospitals for the severely disturbed criminal and would it not be a better idea perhaps to improve facilities within the prison system to deal with this kind of person rather than trying to send them to a hospital where neither the doctors nor the nurses want them?

*(*Mr *Bingley.)* I think it is very difficult to answer the question as to how obviously difficult it is to get people into special hospitals. We know the bad cases and judges pronouncing that it is outrageous that the person who is before them cannot get into a special hospital. It is very difficult to assess how difficult that is. Our basic position is that if someone needs ordinary treatment for mental disorder then the best place to care for them is within the National Health Service. It may well be that in reality the NHS is not going to be able to pick up quite a large number of these people. If that is the case, one has that dilemma as to whether you should actually improve the services within the prisons, i.e., turn them into rather more acceptable sorts of hospitals with the appropriate sorts of standards because I can see there is a major danger of actually sentencing people to imprisonment. I think, as a long-term aim, that is not always appropriate. I think we accept the basic nature of the Mental Health Act in that if someone needs care then the NHS is where they should go. Whether the NHS is likely to be able to pick up the whole need for this sort of care and whether we are in a position to do that is very difficult to know.

Mr Favell: And whether it can recruit the people to do it.

Mr Galley

695. Can we go on further with that interesting interchange with a different topic? You suggest in your evidence setting minimum standards for the Prison Medical Service.

*(*Ms *Shaw.)* Yes.

696. How would you do that and who would do it?

*(*Ms *Shaw.)* I think this point is related to not just the Prison Medical Service, but we would support the argument of other people that minimum standards of imprisonment, as a whole, are needed as a measure, whatever treatment prevails in the Prison Medical Service. We need a set of standards against which to measure it. At the moment we do not have that. All the discussion and debate is not really measured against any ideal standards at the moment. We can just have anecdotal evidence that, we feel, medical care in these places is not as good as it might be or that drugs are used too much or are not used enough. There are no prescribed guidelines with which to compare that. Establishing a minimum set of standards would be quite difficult, but I think it might arise from greater levels of integration between the Health Service and the Prison Medical Service because, although they have not formalised standards in the Health Service, in the same way there are commonly-held beliefs of the formalised sort of standards of care which are appropriate and a closer integration between the services might help to translate those from the Health Service to the Prison Medical Service.

697. You are aiming for standards of care, and not physical and environmental standards?

*(*Ms *Shaw.)* Both. We say they are inextricably linked.

698. It is so much easier to deal with the physical and environmental aspects rather than the quality aspects of it.

*(*Ms *Shaw.)* That is right.

699. We need some idea of how we will tackle the qualitative aspects of standards and how could you do that with the vast variety of care needed?

*(*Ms *Shaw.)* I do not think we have a clear answer for you. We think that this is a problem. I think we could only do it by drawing on what is widely viewed to be good practice within the Health Service and trying to adapt those standards to the Prison Medical Service.

700. Who is going to determine the standards?

*(*Ms *Shaw.)* I think under our proposal, where the two services are integrated, that becomes a job for the Health Service practitioners within the prison and external bodies which would have some sort of monitoring role, such as those which exist like the Mental Health Act Commission, like the Health Advisory Service, for example.

701. If you have integration, do you not always have the great conflict between care and security and how are you going to resolve that?

*(*Ms *Shaw.)* I do not think that the integration of the services poses any problems for security. At the moment there are a number of external practitioners who go routinely in and out of prison. That is the same arrangement as for the education service and the probation service or chaplaincy service within prisons. I do not think that will pose any problems for security in prisons. I do not think that security is necessarily impaired by having health care provided by a separate organisation.

702. Do you not think that by having separate NHS doctors coming in all the time, in fact, there is a chance that the access of the prisoners to the medical service might be reduced?

*(*Ms *Shaw.)* Because there is no full-time medical officer, is that what you mean?

703. Yes.

*(*Ms *Shaw.)* If that was a danger, you would have to guard against it. Obviously the idea is not to reduce medical services to prisoners, but I think what we would see would be an expansion of what happens now. Local GPs would provide personal care to the prisoners, there would be the same range of visiting specialists as there are now, who were called for by the GPs, for the purposes of writing reports or providing specialist treatment and there would also be a role, I think, also provided by the Health Service of commenting on environmental health matters and advising

[Mr Galley *Contd.*]

the prison management on health and safety aspects of the prison system. I think that would be a greater input from the community than is presently the case. I do not really see that would reduce the amount of care available to prisoners.

704. Would not monitoring, whilst keeping a separate Prison Medical Service, produce the same beneficial results?

*(*Ms *Shaw.)* I think that does not cope with the problem of the basic conflict of the role of prison doctors which is, on the one hand, that they are prisoners' personal physicians and, at the same time, they are managers of the prison system. This brings about the problem of trust and it puts great pressure on the doctors and there is a very real set of ethical dilemmas. I do not think that to have an external monitoring system of standards of care deals with that problem.

705. You suggest that the Health Service Commissioner should be involved. What is there that he could do that the Parliamentary Commissioner for Administration could not do now? Do people have access through their MPs and ministers now anyway?

*(*Ms *Shaw.)* We were attempting to broaden the range of options for external criticism by monitoring not just for the Health Service Commissioner. That is one which would be recommended so we would be looking for a role for the CHC within the prisons and the Mental Health Act Commissioner and the Health Advisory Service. Those are options and those avenues provide a much greater availability for external avenues for complaint than at present is the case.

Mr Galley: If you had all those would they not be running round in circles?

Chairman: I think we must press on now.

Sir David Price

706. Could I ask about electro-convulsive treatment, ECT. In your evidence you say: "We note with concern that, in the past, ECT has been administered to prisoners within prison establishments." We got the impression that ECT is used very rarely in prisons and we wonder, first of all, whether you are concerned that it is used. I do not know what your present position is as an organisation about the use of ECT, whether you regret or welcome this. That is my first question. Secondly, would you develop your point that you do not think it should be administered in prison but should be administered in an NHS hospital?

*(*Ms *Shaw.)* Yes. Firstly, the number of ECT treatments is quite limited within prison or given to prisoners whether within the prison setting or as an out-patient in the NHS. Our position would be very much that whether one agrees to ECT or not is a personal decision and should be based on the best information, so that prisoners, as other patients, would be entitled to a full explanation of the likely benefits, potential hazards, of ECT and would be completely free to make a choice.

707. But we know that patients outside prison are often, at the state of depression in which the psychiatrist may be recommending ECT, not in a position themselves to make up their own minds.

*(*Ms *Shaw.)* I think that may be the case in a limited number of instances. What we would wish to see is that at any time during the period of hospitalisation information on all possible treatments is available so that one would not have to wait until the last possible moment when perhaps somebody was very deeply depressed and not able to take in information, to present that information to people, so that they would have a previous opportunity to weigh in their own minds the balance and the pros and cons of any course of treatment. We are not saying we would be against the use of ECT in all circumstances. I think there is a limited role for ECT with acceptable controls, but relating to whether it was within the prison system, our point here is that we would wish to see such treatments being given on an out-patient basis in the NHS, which is what happens now in the vast majority of cases.

708. Surely the safeguards for the use of ECT should be no better and no worse than those for the use of major tranquilisers?

*(*Ms *Shaw.)* Of course we would be keen to see safeguards on all treatments. There is a more limited use of ECT and the first point, as I say, is to have proper information about it and a proper choice.

709. But the use of ECT in recent years has been declining. I had an answer to a Parliamentary Question last week on the total number of treatments and it is not dramatic but the trend is downwards. That would presumably apply to the prison population just as much as to the general population?

[Sir David Price *Contd.*]

*(*Ms *Shaw.)* One would hope so.

710. What evidence have you got percentage-wise that more people are severely depressed in prison? One would be inclined to think that would be probable but do the figures bear that out?

*(*Ms *Shaw.)* Yes, one would think so. I think this brings us into the whole question of measuring the incidence of mental disturbance in prison, which is very difficult. We have looked at the research and it is very largely inconclusive, I am afraid. Estimates of all sorts of disturbance vary quite widely. For example, rates of psychosis within prison are estimated as being roughly the same as in the community, something between 1 and 6 per cent; rates of depression are roughly 9 per cent in the prison population, but there are very wide variations in the research, so it is not possible to say precisely the level of disturbance or the needs of those people or how best to meet them. This is one of the problems we would like to see addressed—much better reserch into those elements.

Mr Winterton

711. Why are you against ECT being administered in a prison situation rather than in an NHS hospital, particularly if the person administering it is, and should always be, fully qualified to do so, bearing in mind the very heavy cost of taking people outside prison to undergo treatment in an NHS hospital?

*(*Ms *Shaw.)* I think the training is the most important factor. The problem arises that in some prison hospitals the staff are not fully qualified nurses with experience of psychiatry. There are occasions when prison hospitals are staffed by hospital officers with a much more limited training. Where nurses are employed they do not always have a fully psychiatric qualification; they quite often have a general nursing qualification.

712. But to get your own attitude absolutely on the record correctly, if ECT treatment was administered by a fully qualified doctor within a hospital situation you would not object to that?

*(*Ms *Shaw.)* We would still prefer treatment to take place in the health service.

713. You would prefer it but you would not stick?

*(*Ms *Shaw.)* I think there would be a strong preference for treatment in the health service at all times.

Chairman: That concludes our questions to you. Thank you very much indeed.

Memorandum submitted by Dr M. Rosen, LRCP, MRCS, DA

Introduction

This Paper is based upon observations made in my work as a GP in the East End of London during the treatment over the years of thousands of homeless people, the majority registered as temporary, as opposed to permanent, patients.

A large percentage of those treated have at one time or another been in prison, mainly for petty crimes which carry sentences of up to six months. The medical conditions they present will cover a wide range of conditions: psychiatric, alcoholism, drug addiction, chest diseases, and peptic ulcer, to name only a few. What surprises me as I see more and more who have been in prison who tell me that they have received some treatment inside, is that I am very rarely contacted by the Prison Medical Service (PMS) to be asked what condition or treatment I had provided prior to my patients' sentence, nor, for that matter, what treatment they had received while serving their sentence so that I could continue with it if necessary. In fact the number of letters I have received over the years can still be counted on the fingers of both hands.

Communication Difficulties With Prison Staff

I have made some general enquiries of the PMS as to why this lack of communication exists. I was informed that every person on entering prison at the commencement of their

sentence was examined and asked for the name of their GP or, if not registered, which doctor they had last seen, and how very few of them admitted to having a GP or even seeing a doctor. The first point is understandable as it is well documented[1 3] that the homeless (which include many petty criminals) have difficulty in registering with a GP. The second point is more difficult to accept in that these same prisoners have no problems when seen at a hospital in giving my name as a doctor they have consulted. Indeed I receive hundreds of letters each year from hospitals all over the country when my patients are "travelling". It is hard to understand their reticence with the Prison Medical Officer when they have no difficulty with a hospital doctor (many of whom write or even telephone, an even rarer occurrence with the PMS than writing letters).

Having questioned a large number of patients nearly all say that they are never asked on entering prison if they have seen a doctor recently and who he was, and they are certainly not given a form to complete which asks for details of the last doctor they saw; yet the PMS has told me that such a form is issued. It is hard to believe that all those patients which I have questioned who have been in prison are part of some general conspiracy to undermine the PMS.

It is not surprising, if I receive no enquiry while they are in prison asking for medical details, that I should receive no letter informing me of their treatment while in prison, as I am led to understand that only those prisoners registered with a GP are given a letter on release—the rest are not! They therefore arrive back in surgery not having a clue as to what treatment they have received. Understandably this does not lead to prompt, or continuation of, treatment in all cases.

I have to admit to a failing on my part in this matter in that I do not write as often as I should to whichever prison my patients have been in to ascertain all the medical facts, but this is partly because some of the conditions they present with do not necessitate knowledge of prior treatment. Furthermore, my knowledge of actual prisons is limited to the only one I have visited—Pentonville (where most of my patients end up or have been)—so that many of my comments refer directly to that establishment. The others might well be better, although I have had patients from elsewhere and have not heard from any of those establishments. It will be for others to confirm or deny my fears. It is fair to say that one prison where the response has been excellent is Winchester.

My reason for visiting Pentonville and meeting the medical staff, amongst others, was to find out if there were ways to improve communication between us. On the basis of homeless prisoners' denials of having seen a doctor and given that I and a couple of other doctors see large numbers of such people in East London and some from further afield, it was suggested to the prison doctors that, as a way of improving communications and helping them in their work, they could contact us on spec. regarding any homeless prisoner they received from the London area for a background of the medical conditions and treatment. Although not ideal, in that some will not have received treatment from us, it was to be hoped that it would provide at least one point of communication or referral and improve their knowledge of some of the prisoners in their care. Subsequently they were furnished with surgery addresses and times of attendance, but it is most disappointing to report that, to date, not one of us has heard a word. Yet since that meeting our patients have been in and out of Pentonville.

Housing for Ex-Prisoners

This attitude is further confirmed by the indifference to another offer of help made to the staff at the same meeting. They mentioned that they had the greatest difficulty in being able to place a homeless prisoner in accommodation on his release, having telephoned round the local hostels to be told always that there are "no vacancies". Knowing the voluntary sector in the East End I said that if the officers concerned with this work would like to get in touch with me I could provide addresses of hostels and the name of a contact. I later checked with all the hostels in the area as well as a number of day centres where meals and social services support is provided for homeless people, for I was surprised by the "no vacancies" comment, although I did not know which hostels in London they might have tried. I was

even more surprised, in fact quite shocked, to be told by all of them that they had neve received a request for assistance from Pentonville, nor, for that matter, from any othe prison. They all added that they would be more than willing to help and, knowing them as do, I know they mean it. When writing to thank Pentonville for arranging my visit repeated the offer. There has been no reply, which leaves one wondering who the telephone, if they do, since there are more hostel beds in Tower Hamlets than in nearly a the other London boroughs put together and such hostels claim never to have received call from Pentonville.

One is left with the feeling that insufficient effort is made by the PMS to look at the need of prisoners and to realise that their work does not stop when the gates shut behind th prisoner upon his release. It might be nice to say "I have done my bit while he was inside now it is up to those outside", for, if that is so, in my view it is an abnegation of the prisons responsibility if part of the responsibility is to try to enhance the individual's return t society.

Special Problems of Alcoholics and Drug Addicts

At Pentonville this is seen in their treatment of alcoholics and drug addicts (and it woul be interesting to know what happens elsewhere) whom they claim to wean off in a few days giving no replacement therapy, only strong sedatives. This could safely be said to b inhuman. It is therefore no wonder with the alcoholic or drug addict, particularly if he is i prison for only a few weeks, that, on leaving prison and finding himself once more homeles and without support, he is back on the street looking for a drink or a "fix". The prison service has made no attempt to try to combat the psychological, as well as the physical dependence, the former being the more long-standing problem. It is to their shame for while the person is in prison (a captive audience) there is a wonderful opportunity to star the process of healing which can then be continued if a determined effort is made to plac the individual with outside medical and support agencies.

I am frustrated and angry in seeing large numbers of homeless patients with psychiatric alcohol, and drug addition problems, all of whom need long-term care and support, and knowing that their particular problem was a contributory factor in getting them into trouble with the law. In the majority of cases between the time of their discharge from prison and being seen by a doctor they have reverted to drugs and alcohol. This is no surprising in the absence of support and returning to their previous environment as it is the only one they know. They end up in the same position as they were before entering prison more than likely to fall foul of the law once more and end up in prison. The revolving doo situation then arises: in and out of prison.

Treatment

A further frustration about this situation is having to start treatment from scratch—much harder with a homeless, noncaptive audience—when only a few weeks or even days earlier while in prison, treatment had been initiated and, because no effort has been made to ensure its follow up after release, whatever efforts had been made in prison were wasted. It is easy to understand the despair of the PMS in seeing the same faces coming in and out with their alcohol and drug-related problems and wondering what they can do. I feel the same way with some of my patients. I agree that the treatment of such conditions is often a thankless task with the success rate for ever being poor, particularly with alcoholics. However, if we are to have any chance to improve this rate one of the ways forward is undoubtedly a closer link with greater understanding between the PMS and the doctors and other agencies helping these people in the community; this also includes the provision of accommodation. There is no doubt that those who are able to find a stable base tend to do better in their recovery programme. This has been very much borne out in Tower Hamlets where a certain number of homeless alcoholics have, through the GLC, been provided with permanent accommodation once they are on the mend. Practically without exception they have gone on to do well and have not relapsed into alcoholism; they still need long-term support from different agencies, but the task is made much easier.

Possible Solutions

There are no easy instant solutions to the problem for it comes back to the desire of the individuals involved wanting to make a greater effort to help. The lack of effort may well result from a feeling of hopelessness, so that any solutions must be oriented towards making all those involved both outside and inside prison feel that their efforts are worth while by actually seeing some progress. This applies equally to those helping and those being helped otherwise those prisoners with long-term medical problems will continue to be forgotten men, as so many of them already are.

1. All prisoners on their release should be given a letter stating any medical conditions which have received treatment while in prison. No doubt some prisoners will lose the letter but that is no reason for not giving it, because those who are able to hand it to the first doctor they see, quite apart from helping themselves and the PMS, will be aiding the GP by ensuring quicker and more prompt attention. This would avoid the GP having to check over the story and, moreover, what might be an even better outcome of this is to make GPs more accessible to the homeless than they have been hitherto.

2. On entering prison it must be a regular routine, without exception, for all prisoners to be asked who their GP is or, if not registered, who was the last doctor they attended for treatment. The natural follow up from that is for the doctor they have been seeing to be contacted so that their past medical records can be obtained. As a GP it is always helpful to have a patient's past medical record, even if it is not relevant to the condition they are presenting. It can be no less helpful to the PMS.

3. All prisoners' medical records should be centralised and placed on a computer. This would make it easier for any GP who might have a query to obtain rapid information. Centralised records are already available for drug addicts from the Home Office Drugs Unit, Queen Anne's Gate, SW1, which normally replies to any query raised by a GP within an hour.

4. If prisoners with psychiatric, alcohol, or drug-related problems are to receive long-term support on leaving prison this work must commence while there and requires the appointment of staff whose only concern will be this problem and nothing else which might be involved with running the prison. A procedure already operated by district general hospitals and long-stay mental hospitals is for the local authority in whose area the prison lies to provide a team of social workers seconded to the prison. This will naturally require funding, but if there is genuine concern for it to work there should be no reason why the Home Office should not earmark special funds for the purpose instead of the local authority Social Services Department feeling that this is just another group competing for whatever funds are available, and then perhaps feeling that it is not a high priority with the result that only a token force of social service workers would be allocated to the prison service with the well-known result of such gestures. The provision of special funds would overcome the feeling of the local authority that it was having to use its own funds for people coming from outside their area.

Conclusion

The possible solutions will admittedly not produce an instant overnight improvement because, in the long term, that will come about only by a change of heart in the prison authorities concerning such work within prisons. However, not taking the simple steps suggested is, I believe, a recipe for disaster which can lead only to a worsening of the current situation.

References

1 "Homeless and healthless". Hackney CHC, 1981.
2 Conference between CHAR and Association of CHC England and Wales, 1981.
3 Paper prepared for Tower Hamlets District Health Authority, 1984.

Examination of Witness

DR MAURICE ROSEN, General Practitioner, London E1, called in and examined.

Chairman

714. Good evening, Dr Rosen. Thank you very much for the document that you sent us and for agreeing to come and answer some questions. We have not got a lot of questions we want to put to you, and we apologise that we have kept you rather a long time but we cannot legislate for that.

*(*Dr *Rosen.)* At least my bleeper has not gone anyway while I was waiting!

Mr Winterton

715. Can I put a couple of very important questions to you because obviously we are very interested in your background. Could you tell us something about your own particular practice, although we do know quite a lot about you from the excellent paper you have sent us? How many of your patients, Dr Rosen, have been in prison?

*(*Dr *Rosen.)* Of the 2,000–2,500 homeless I see each year the majority have spent time in HM hotels at one time or another.

716. Could you then also give us some description and idea of the extent of your practice, the range of your practice, the problems of your practice?

*(*Dr *Rosen.)* Yes. It is an inner-city East End practice in the Borough of Tower Hamlets, where I have permanent patients and where I also treat the homeless, because I have always had an open door because, to its shame, my own profession has slammed the door in their faces for one reason or another and I have been prepared to see them. Having got a reputation for having an open door, it spreads on the grapevine and one has more and more people turning up on one's doorstep.

Chairman

717. Are you working single-handed?

*(*Dr *Rosen.)* Yes.

Mr Winterton

718. But your comment is fairly damning of your own professional colleagues?

*(*Dr *Rosen.)* Yes, and it is well-documented that the medical profession as a whole does not look after the homeless. If you ask any of the voluntary organisations if the homeless in the broadest span do, in fact, get turned away, and the more de meaning as the public might call the hom less—and that is a euphemism in certai cases for, let us say, the alcoholic, the dowr and-out vagrant, the individual on "ski row"—in the vast majority of cases the have the door slammed in their face. The are very lucky even to get through the fror door and past the receptionist. There are number of reasons and all the voluntar organisations will bear this out, and that the tragedy. In a way the conflict in th prison medical service is exactly the sam because I saw an article in the Lancet abou two or three months ago, where a docto who had written in had made the commer that only 20 per cent of GPs written to b the PMS reply, because one of the points make is that I had never understood wh over the years one had never received an communication from the prison medica service, and there are so many people wh are in prison, when I receive communi cations from hospitals up and down th length and breadth of Great Britain. In m dealings with them we get on very we together. If they are quite prepared to giv my name to hospitals throughout Britain why should they suddenly feel apprehen sive when they get into Pentonville c Wormwood Scrubs or Reading or Oxfor about giving my name? Where one ca possibly defend the Prison Medical Servic is if they have been rebuffed when the have approached doctors in the past fo information. They might well feel, "Is ther any point taking it on?"; as I said before most GPs do not reply. It must be a two way dialogue, although I have qualm about that from seeing the letter from D Kilgour in this morning's Times where h says that two-thirds of the prison medica establishments are staffed by part-tim medical officers who are general practition ers. That raises one question; if they ar GPs, and we know that most GPs do not se the homeless, do these GPs, who are part time medical officers, attend to these indiv duals if they come before the surgery doo outside of prison? In the main, I think th answer would be no. In that case, they ar not shining knights; they are doctors behin closed doors. It always raises the view which might be unjustifiable, but the sug gestion is there that if they are not doin any work outside with the homeless, wha work are they doing inside when they se

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he same patient they perhaps have previously rejected?

719 What is your answer?

(Dr Rosen.) I might be libelling. All I can ay is that I do not believe, from the patients see which, over the years, is thousands, that hese people operate some grand conspiracy vhen sitting in the parks of London and ay, "We are going to see Dr Rosen. Let us pin some yarn and tell him that the service vhich we do not get is hooey." As the old aying goes, where there is smoke there has o be a fire. I agree with what I am being old. In fact, I am relying on what these atients, prisoners are telling me. Some are nes whom I have got to know over the years nd I just do not disbelieve them all.

720. Why did you choose to tread this ath which clearly will put you at loggerheads with the overwhelming majority of our own professional colleagues? Is it a rofessional ambition? Is it a political mbition? Tell me, why are you doing it?

(Dr Rosen.) People can be accused of many things. My view at the end of the day, ny own moral belief, is if someone requires elp, they are entitled to it. There is an old almudic saying which has stuck in my nind since the days when I was wearing hort trousers—and I might still be accused f wearing short trousers—that a man was sked why he continually gave help to eople who asked him for it. His friend said o him, "Why do you not realise that many eople will take advantage of you?" He aid, "Is it not better that many more should ake advantage of me than to turn away one vho really needs me?"

721. So the main criticism of the Prison Medical Service seems, from the evidence ou have submitted, to be the lack of ollow-up following the release of a person ack into the community. Can you suggest ow this can be improved, giving the imited resources which are available to the rison Medical Service on the one hand and he National Health Service on the other? erhaps I should say the "finite" resources, ot the "limited" resources.

(Dr Rosen.) I think we all realise that the ake can only be cut into a certain number f pieces. Even if everyone was taken on oard or even 95 out of 100 cases, we still ould not be successful in getting the end esult which we wanted to get; the psychiatic, drug addict, alcoholic patient to become the ideal individual in terms of their atural health, which we would want. There are certain steps I would like to see. One, I believe, is that all prisoners, on being discharged from prison, have to be given a letter stating what medical treatment they have received and what condition they have been treated for. When I saw the Prison Medical Service, I was told that the only prisoners who were given a letter were those who were registered with a GP and that the rest of them were not on the basis that they would most probably lose it or would not be bothered to give it. I find that nonsense. The vast majority of the homeless, whom I see, who are discharged from hospital have no difficulty in giving a letter to me, which they have been given in hospital, irrespective of whether they have carried it all the way from Glasgow or from a London hospital. I do not see why that same individual, who has been discharged from Pentonville, or wherever else it may be, should lose it even if he has a further distance to come. I think this is why the Prison Medical Service has to be more open, if only to show to people outside that perhaps there are no fears for individuals to have. If you are not prepared to tell people what you have been treating some people for and what medication you have prescribed, what are you hiding? The suspicion is there. It might be totally unjustifiable, but it raises a suspicion and that is what they have to get rid of. There are a number of things. I do not think you can isolate what you do for them outside from what might be taking place inside and I will come back to the inside in a moment. I think, as with a lot of these individuals who are alcoholics, drug addicts, it is not the immediate physical need in terms of treatment that is the short-term view. It is their psychological dependency that needs to be treated at the same time if you are weaning someone off drugs as you are detoxifying them in terms of alcohol. What matters is the long-term back-up which you provide. If you provide that you can get, in a large majority of cases, good results. As Dr Glatt says, who is the Head of the UCH unit, in a recent letter to the BMJ, it is absolutely right that what matters is the continuation of treatment. When I went to Pentonville —and I said it in the paper and really it applies to all the other prisons—they said to me, "We can never find the accommodation." I said to them, "I know all the voluntary organisations so if you are interested, let me know and I will give you the names and addresses." Not a bloody word! Then, in fact, I contacted Dr Kilgour and he said, "Let me have it, Dr Rosen." This was a list of all the voluntary organisations and

[Mr Winterton *Contd.*]

agencies and it went out to all the prisons in London and the south-east and none of those voluntary organisations have heard a word. It raises the question as to how interested are those in the prison service who talk about what they want to do in terms of continuing treatment outside and what they actually do about it. They do not seem to do very much between talking and doing. I agree that you cannot change people's minds and if they do not want to do it, they are not going to do it unfortunately, but at least the help is there. The voluntary organisations are prepared to help, but they are not, in fact, approached and that is the tragedy of the situation.

722. You are blaming the individual prisons rather than Dr Kilgour?

*(*Dr *Rosen.)* Yes, Dr Kilgour, I have the ulmost respect for. I think he cannot be everywhere at the same time all the time.

Chairman

723. Dr Rosen, when you went to Pentonville, you talked to the prison medical officers there, did you?

*(*Dr *Rosen.)* And, in fact, some of the prison officers in the hospital setting.

724. When you put this point to them about notifying GPs when their flock went out of prison and you asked them why they did not do it, what was their answer?

*(*Dr *Rosen.)* I do not think I put that particular question to them.

725. You should have done. You do feel very strongly about it.

*(*Dr *Rosen.)* It was a question which I put to Dr Kilgour as to why it did not happen.

726. That was in writing?

*(*Dr *Rosen.)* Yes.

727. And you did not get a reply back?

*(*Dr *Rosen.)* Yes. Dr Kilgour was always very frank. I am certain that his concern for how he would like to see the service develop is absolutely genuine. One often finds in lots of organisations the person right at the very top is absolutely genuine. If you could cut him into about 100 pieces you might get a better service, but, unfortunately, you cannot.

Mr Patchett

728. In your paper you refer to the Prison Medical Service's apparent indiffe ence to offers of help from outside agencie Is this, in your view, an institutional indi ference or perhaps even stemming from th Home Office, or is it the apathy of indiv dual prison medical officers?

*(*Dr *Rosen.)* It could well be one or could be a combination of all of them. If i the majority of prisons the medical office are part-time and, therefore, general pract tioners—and general practitioners in th main do not wish to see the homeless, th down-and-out vagrant, whatever name yo want to use—then the apathy may ste from them because if they are indifferent t them outside they are going to be indiffe ent to them once they are inside. It could b any one over the others. It would be nice one had been to every prison and had bee able to stay there for two or thre months—being able to let out perhaps no and then!—to get a general feel, but fro what patients, prisoners, tell me, the always seems to be an undercurrent, tha the way they are dealt with inside priso tends to be on a very indifferent basis.

729. Where would you put the blam though, with your experience of ex-prisor ers? Are we talking about institutiona indifference or the reaction from individua prison medical officers?

*(*Dr *Rosen.)* I think it is a combination c the two. I think it is institutional indiffer ence and individuals, because all that ha happened, as I mentioned in my paper, i that in the last 15 years the number c letters I have received from the priso medical service I can still count on th fingers of one hand. Since making tha comment, it is interesting that in the las nine months it has gone up by 50 per cent. have had four telephone calls. I suppose thi was a sort of gesture to Dr Rosen that, i fact, something might be improving.

730. Could you expand on the proposa for collaboration that you made to th medical staff at Pentonville and on thei response? I know you have touched on i briefly.

*(*Dr *Rosen.)* The response has been absc lute "zilch".

Chairman

731. It is nice to have a witness with sense of humour!

*(*Dr *Rosen.)* Basically I feel very angr about it because it is an absolutely tragi situation. One can smile and laugh about i

Chairman *Contd.*]

but in the last two weeks I have had five homeless vagrants who have died because of the temperatures outside, about whom no-one has given a damn. If it had been "Crisis at Christmas" or a much larger number than five or it had been in Africa there would have been questions asked and everyone would have been beating the table, but because it was four or five individuals whom no-one gave a damn about, who were nameless, whom no-one knew about, it did not really matter. These people *do* matter because they have absolutely as much right to the service as the rest of us, who take it for granted, and yet they do not receive it.

Mr Winterton

732. Are these ex-prisoners you are talking about?

*(*Dr *Rosen.)* Yes, ex-prisoners and the homeless. They are on the streets.

733. Should they have been in prison in the first place?

*(*Dr *Rosen.)* No, quite honestly not. One knows the law about alcoholics was changed recently so that people with alcohol problems are not supposed to be sent to prison—the Home Office, God bless them! The courts now send them to prison because they cannot pay the fine. That is absolutely illogical. All right, it protects them—as one of the earlier witnesses said—from dying two weeks earlier than they might have done because they are in Pentonville or Brixton for two or three weeks. The tragedy of the situation is that you have a captive audience. They might not want to be there but if they are able to start treatment there the important thing is that some effort must be made to continue it on the outside, otherwise you have the revolving door. As Norman Fowler said in The Times on Monday—if he was quoted correctly—no psychiatric patient should be discharged from a long-stay hospital unless there are facilities in the community. The same thing should apply to prisoners, absolutely so. There is no difference.

Mr Favell

734. What you say is very interesting. I think our experience as a Committee is that the after-care service is better in the north than in the south. That has been our experience and it is one occasion when the south has something to learn from the north. What I would be interested in hearing from you, with so much personal experience of alcoholics, for example, is, what is your success rate?

*(*Dr *Rosen.)* I cannot claim to have a great one. At the end of the day if I can keep them off alcohol for long periods of time I claim it as a success. The tragedy is that I have not been able to research it. It would have been nice if one could have. What one can say certainly is with those individuals whom we have been able to get off alcohol for three months and have been able to get them a stable base through what the GLC has done in Tower Hamlets in providing accommodation, the relapse rate is absolutely minimal.

Chairman

735. Even though they may not have been able to get a job?

*(*Dr *Rosen.)* That is right. The result is absolutely tremendous.

736. They still have the same psychological problems they are struggling with?

*(*Dr *Rosen.)* Yes, but it comes down to the long-term support. They are given back some self-respect; they realise they are able to do something; they are not pushed from pillar to post as they are when they do not have a permanent base. This is the trouble with lodging houses. The lodging houses have their own regulations and if they play up they may be tossed out and go back on the bottle. The whole thing becomes a vicious circle.

737. Supposing in prison we could tackle the problem of the psychological dependence on drugs and alcohol. I understand from your paper you say this provides a very good opportunity to start to do that?

*(*Dr *Rosen.)* Certainly.

738. What sort of treatment do you think they ought to be given in prison?

*(*Dr *Rosen.)* One has to wean them off the physical dependency as well as providing the initial psychological support.

739. We are not going to get this when they are in prison?

*(*Dr *Rosen.)* The way they are weaned off at Pentonville, if that is an example as to how they deal with drug addicts, and the other prisons do exactly the same, God help us, quite honestly.

740. Tell us what they do in Pentonville.

*(*Dr *Rosen.)* In Pentonville when someone comes in who is a heroin addict, say, very high on a particular dose, they say they

[Chairman *Contd.*]

wean him off in three days. When I said, "At the end of three days, having blown this fellow's mind with withdrawal symptoms, what do you do?" they said, "We heavily sedate him with Largactil." This is what they call care and professional treatment. If this is how they behave, I would not touch them with a bargepole.

741. How long do they keep them on Largactil?

*(*Dr *Rosen.)* It depends on the individual case, but that is not the way to treat someone who is a heroin addict. If he is only in there for three or four weeks and you have taken him off in that time and have doped him up to the eyeballs with Largactil and you then kick him out of the door without any medication, it is not surprising that with no support the first thing he is looking for is a "fix". He might be on a fixed dose. He might be on half a gramme a day. The money is £30–40 a day. He is not working. The only thing he can do is get back into crime. It is as if the prisons want to perpetuate their own existence and the only way they can do that is to have people coming in and out.

742. If you were Dr Kilgour what would you do in that situation? You would not give him Largactil?

*(*Dr *Rosen.)* Obviously no. If you are going to wean someone off heroin properly you are going to use one of the replacement drugs and do it in a series of steps, and you are not dogmatic. You do not say because someone is on such-and-such a dose you are going to do it in 10 days or a month or three months. Everybody is an individual and you base your treatment on that individual. But equally as important as weaning them off the physical dependency is the psychological dependency, because that is a much longer-term scheme than the physical dependency. Here possibly I would want to incorporate the voluntary agencies, who do have tremendous experience in providing psychological support, involve them in the prisons or using them when the prisoner is discharged, but having made contact before his discharge, because what is very important is, whether the prison service is run by the Home Office or the NHS I do not thir matters but it is the individuals who run who matter. I think what you do need have is the staff who are in it separate fro the prison service in so far as they are n prison officers. You would use outsi individuals there because then I think yc would be able to get an understanding, confidence, a relationship with the peop you are trying to help, because in particul with alcoholics or drug addicts even on th outside it takes time to build up confidenc The reason they come to see me, eve though some of them might feel I am a easy touch—and that is probably true— that at least they know that no matter wh they are, what they are, their treatment is n different from anybody else who walk through my door, so we build up a relatio ship. But you cannot do it overnight; the is no immediate answer, just like that.

Mr Winterton

743. Why are you on your own in thi single-doctor practice?

*(*Dr *Rosen.)* Because I am a "bolshie individual. I think it would be very difficu for anyone to work with me!

Mr Favell

744. Are you married, Dr Rosen?

*(*Dr *Rosen.)* I am indeed.

745. You must have a long-sufferin wife!

*(*Dr *Rosen.)* She is an angel.

Chairman

746. Do you have a receptionist as well

*(*Dr *Rosen.)* I do everything myself. I an termed now as an "old-fashioned doctor". do all my own visiting. If patients want me they have me. I visit my elderly patient once a month who cannot get to the surgery

747. You are a very conscientious doctor

*(*Dr *Rosen.)* I like to think so.

Chairman: Thank you very much indeed We are most grateful to you, Dr Rosen.

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HOUSE OF COMMONS

SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

Wednesday 26 February 1986

Howard League

Mr Andrew Rutherford, Ms Frances Crook and Dr John Taylor

National Association for the Care and Resettlement of Offenders

Ms Vivien Stern and Mr Paul Cavadino

National Council for Civil Liberties

Mr Tim Owen, Ms Marie Staunton and Professor Derek Russell Davies

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WEDNESDAY 26 FEBRUARY 1986

Members present:

Sir David Price, in the Chair

Mr Roy Galley
Mr Charles Kennedy
Mr Nicholas Winterton
Mr Tim Yeo

Memorandum submitted by the Howard League

1.1. The Howard League for Penal Reform was established in 1921 as a result of the erger of the Howard Association and the Penal Reform League. The Howard Association d been founded in 1866, named after John Howard, High Sheriff of Bedfordshire an defatigable scrutineer of prison conditions in this country and abroad in the latter part of e eighteenth century. Even before publication of "The State of the Prisons" in 1777, oward's efforts had prompted the 1774 Act for Preserving the Health of Prisoners in Gaol d Preventing the Gaol Distemper. This legislation required all prisons to appoint a ctor but localized prison administration made this and related reforms difficult to force.

1.2. The Howard League has continued to seek radical reforms in the penal system, and s campaigned for a criminal justice system that is humane and effective. It has long gued that a large proportion of the men and women sent to prison should not be there. ternatives are available for many property offenders which comprise the majority of ose in custody today, and alternatives must be developed for drug and alcohol related fences, for the mentally ill and for those on remand. As a recent report commissioned by e Howard League pointed out the custodial remand is dangerously easy to administer. ne following observations on sex offenders have a wider application.

1.3. "There are several obvious reasons why an offender remanded for examination on il stands a greater chance of being recommended for treatment than one remanded to ison. First, the prisons deal with more socially aliented, poorly motivated and recividistic fenders who are less likely to respond to treatment. Second, the prison medical officers nnot offer treatment themselves, but must arrange it by calling upon a National Health rvice colleague. This can involve protracted and sometimes frustrating negotiations, nich are likely to be undertaken only in very serious cases or where offenders have some rid psychiatric illness. Prison medical officers rarely recommend outpatient treatment on obation, perhaps because they are in less close touch with facilities in the community an are the consultants working in the locality. The nearest remand prison is often many iles from where the offender lives. Relatively mild psycho-sexual problems, such as might ert an outside consultant to a need for treatment, are easily lost sight of against the ckground of an inmate population with a high incidence of psychiatric disorder. While eoretically a custodial remand allows opportunity for observation, in fact the pressure of ork at a busy remand prison is such that the interview with the doctor probably takes ace only in the third and last week of the remand period, and often without the benefit of uch information from the probation service about current social circumstances, previous eatments or assessments of personality." (*Unlawful Sex*, 1985, pp 111–112)

1.4. The overall aim of substantially reducing the prison population must be borne in nd when any aspect of the penal system is discussed.

1.5. The quality of health care provided for inmates of penal establishments is often low the standard of health care in the community. Inmates are admitted suffering from a

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variety of physical and mental disturbances, but opportunities and incentives to liaise w family doctors and provide appropriate treatment regimes are lacking. Detention in pris is a health hazard owing to the very poor standards of hygiene in some institutions, the la of trained nurses even in establishments housing numbers of chronic sick, and the abser of 24 hour residential medical cover in remand prisons housing many acutely disturbed a suicidal inmates. These deficiencies are exacerbated by the grotesque overcrowing found many local prisons. As HM Chief Inspector of Prisons notes in his annual report for 19 "The sanitary conditions in many penal establishments in England and Wales uncivilized, unhygenic and degrading . . . When time for slopping out comes the prison queue up with their pots for the few toilets on the landing. The stench of urine a excrement pervades the prison. So awful is this procedure that many prisoners beco constipated—others prefer to use their pants, hurling them and their contents out of t window when the morning comes." It seems that the threat to basic health care in ma local prisons cannot be far removed from the alarms raised by Howard and others t centuries ago.

2.1. *THE CASE FOR FUNDAMENTAL IMPROVEMENTS IN THE QUALITY O MEDICAL CARE*

Until recently, in Brixton prison when a man was initially received he underwent medical examination by standing naked in front of the medical officer and rotating. He w not touched, but just looked at. Bearing in mind that his medical notes do not go into pris with him, this is a grossly humiliating and inadequate examination, but not atypical of t standard of care, and caring, throughout the system.

2.2. Hospital prison officers in England and Wales are trained for only 26 weeks on in-service basis and not by NHS nurses. Prison officers are not encouraged to develop th skills in nursing care.

2.3. The prison medical service is widely considered to be low status, low paid and wi very poor career prospects; half the full time doctors in the prison service are over 55 yea old. For many prison doctors, the job is regarded by them and by others as being "de end". Where service morale is low, and interest in professional improvement and keepi up with advances is lacking, standards of care suffer. Whilst some professionals are expe skillful and sensitive they are hampered by lack of time and poor work conditions a facilities.

2.4. As stated above, the Howard League has for a long time campaigned for substantial reduction in the size of the prison population. Among the categories of peop now in prison who should be removed are persons deemed to be mentally ill. The failure the Regional Health Authorities to provide secure units and the failure by local hospitals accept difficult patients is to be deplored.

RECOMMENDATIONS

3.1. *Integration into the National Health Service*

The Howard League recommends full integration into the NHS and abolition of th Prison Medical Service as the first step towards improving the quality of health ca throughout the prison system. Full integration into the NHS, as we see it, goes rath further than some of the proposals already put to the Committee

3.2. Once inside the NHS medical services could be administered and co-ordinated b the Family Practitioner Committees. The FPC would provide primary health care (GI and dentists etc) and would call in services such as psychiatrists as necessary. It would b possible for one FPC in a region to act as an agent to liaise with other wings of the NHS lik the Regional Health Authorities and the District Health Authorities for specialist service There are several advantages to such a proposal. Firstly, it would bring prison medicir into mainstream health care and would end its being virtually a "secret service". Secondl it would be integrated into the democratic management structure of the NHS with th involvement of local politicians and practitioners. This should mean that the Communit Health Councils could investigate complaints. Also, it would be possible to see that medic notes were transferred into the system along with the prisoner which does not happen at th

oment (at least not for people serving less than two years). It should provide a more mprehensive and supportive aftercare service as there could be continuity of information id contact. Prisoners could even be given a choice of GP.

3.3. Already most health care in prisons is provided by the NHS through part-time GPs id dentists and psychiatrists. Prisoners needs, due to their special situation and the prived groups from which many of them come, are far greater than those of the average tizen. It is therefore vital that the budget for the medical service is fully safeguarded and at it should not come under attack or suffer cuts. Because prisoners are not popular ople the political will must be firm about the protection of funding.

3.4. There is an urgent need to bring in some kind of accountability to medical care in isons and to lessen secrecy. Therefore, it is recommended that the Official Secrets Act ould no longer apply to penal institutions at all. Open and public debate, based on facts id knowledge, on penal policies and conditions is a necessary prerequisite to penal form. The PMS has been excessively secret about the type of care provided which in itself is resulted in misunderstanding and poor standards. The Howard League recommends ll integration into the NHS to open up medical services in penal establishments to public rutiny and debate at local and national levels. All health provision should be sensitive to rofessional and public criticism.

3.5. As a consequence of full local integration some changes will have to be made. sychiatric reports need continuity of contact and regular interviews, and the NHS would ive to make provision for this. At the moment some such reports are done on remand isoners by Medical Officers who may not have any psychiatric training at all. The vast ajority of such reports can be done in the community and do not require a person being manded in custody, but those few who would need to be detained should be examined by HS psychiatrists. The NHS will have to develop forensic psychiatry in order to be able to ovide the courts with prompt and comprehensive medical reports on offenders remanded n bail. This would prevent unnecessary remands to prison, where specialist medical and cial background investigations are more difficult to arrange. This should allow people to t a second opinion of their choice.

uality of care

4.1. The quality of health care must be improved. It is vital that the work environment id facilities of all medical and nursing staff are also improved urgently.

4.2. Doctors working in penal establishments should be encouraged to get specialist aining, for instance in venereal diseases. To achieve this there should be a training ogramme similar to that operating in the armed services which allows for limited acements for young doctors. Academic and research work should be encouraged. The atus of medical staff working in penal institutions must be improved, and to do this career ospects and opportunities should be developed, perhaps through the creation of ademic posts and by increasing the throughput of doctors so that they do not get stuck in rut as has happened in the PMS.

4.3. There should not be special treatment centres for drug addicts or alcoholics inside isons as this would only encourage their being sent to prison. Instead these specialist rvices should be provided by the NHS within the community, in hospitals and in sidential clinics.

4.4. Regional Secure Units should be established to take the mentally ill or disturbed ople, who do not need special hospitals, and the NHS must be encouraged to take entally ill offenders who do not need the added security of RSUs.

4.5. Doctors should not be involved in prison management but must be professionally dependent. If a doctor is involved, as at present, in management of the establishment or nishment, the patient/doctor relationship is deleteriously affected.

4.6. Doctors should not be involved in punishment. Currently doctors have to cert that a prisoner is fit for punishment, but it is not ethical for a doctor to appear to sancti punishments.

4.7. There have been allegations that medicines have been used punitively. At no ti should medicines be given for punishment, control or for disciplinary reasons.

4.8. The prison rules still allow for doctors to attend executions. The death pena remains on the statute book for a limited number of offences. Doctors should not be ask to take part in executions under any circumstances and this clause must be deleted.

4.9. The possibility of prisoners consulting their own doctors should be investigated

4.10. Prisoners should have access to a second opinion far more easily than is the case present.

4.11. Women prisoners should have the right to ask to be treated by women medi staff.

Nursing care

5.1. All nursing care should be provided by NHS nurses, fully trained inside the NH and employed by them. Nurses should continue to be members of the relevant professior association (the Royal College of Nursing) or trades union (the Confederation of Heal Service Employees or the National Union of Public Employees). There must be no confl of interest between the caring role of nurses and the discipline and controlling role of t prison officer, and in order to avoid this the two professions must be separated.

Environmental Health

6.1. Crown Immunity should be lifted from penal establishments and the responsibili and power to inspect and enforce environmental health standards should be transferred local authorities. Now that a commitment to lift Crown Immunity from hospitals has bee given by the Government, the same must be done for prisons.

6.2. Community Health Councils represent consumer interests inside the NHS, and the statutory right of inspection should also be extended to cover penal establishments. Tl principle and practice of consumer representation should exist in the penal system as in tl community.

Examination of Witnesses

MR ANDREW RUTHERFORD, Chairman, MS FRANCES CROOK, Director, and DR JOH TAYLOR, Consultant Psychiatrist, Royal Free and Friern Hospitals; Adviser in Forens Psychiatry in NE Thames Region, Howard League, called in and examined.

Chairman

748. Good afternoon. In the absence of Mrs Short, who is on other business, I am taking the chair. Welcome to you. Could you introduce your team?

*(*Mr *Rutherford.)* I am Andrew Rutherford; I am Chairman of the Howard League. On my left is Frances Crook, the Director. On my left is Dr John Taylor.

749. We thank you for your memorandum, which we have read with interest. Yo will not be surprised to know there ar certain features in it common to many othe memoranda. Therefore, in our questions w want, above all, to clarify points and also t discuss points that you have made whic are unique to your paper. If we do not g through all of it, it is not because we hav not absorbed it. Other witnesses have advc cated the transfer of the prison medica service to the DHSS. In their submissions,

Chairman *Contd.*]

imber have opted for the concept of a ecial health authority status rather than raight integration into the local district or gion. You in your turn have rec-nmended responsibility should pass to the amily Practitioner Committees rather an to the DHSS or the RHAs. I wonder if ou could develop your choice of the amily Practitioner Committees as being e right home, as it were?

(Mr *Rutherford.)* I think this came from ir concern for real and substantial change occur and to move in the direction of a ecial body, such as the one that you have entioned, might perhaps be regarded as a tisfactory interim step to take, but the nger that we saw was that it might remain ere and that if one really is trying to open the question of quality of health in isons, if one really is trying have people orking within the prison system, who are oking out, and equally important, many eople working outside looking in, that to ove directly towards the sort of model that e are proposing perhaps makes rather ore sense. So we did consider this point at, as you say, a number of other people ave recommended. Our view was that full tegration ought to be teased out as an tion and given some emphasis by this ommittee.

750. If they are brought under the Fam- Practitioner Service they would still have have the same relationship with the amily Practitioner as with the District and egional Health Authorities, would they ot?

(Mr *Rutherford.)* That is right.

(Ms *Crook.)* We looked at all the various tions, the DHA and the RHA and the amily Practitioner Committees, and ought that on balance the Family Practi-oner Committees were the most suitable ace to put the Prison Medical Service ecause of the new autonomy they have got the reorganisation, because for the mo-ent they are not bound by budget limita-ons, although we realise that is going have to come. We are very concerned at the budgets for any Prison Medical ervice should be clearly protected, so that ems, for the time being, a good place to it the service, also, because the Family ractitioner Committees are responsible for imary health care in the community in a ry direct way, looking after health care cords and that kind of thing. So it was felt at that was the most suitable place to put e organisation. Whichever tier took over the organisation of the Prison Medical Services inside prisons, they would have to take on a coordinating role as well and the administrative role, with other wings of the health service, with the DHAs and the RHAs, for psychiatric services and other specialist services. It was felt on balance the most practical place to put it was in the Family Practitioner Committee.

751. Have you tested the idea with anybody who is involved in the running of the Family Practitioner Committees?

(Ms *Crook.)* Informally.

752. What sort of reaction did you get?

(Ms *Crook.)* I tested it with people who I know are involved in the North of England and in North London, and people working in hospitals as well in the administrative side. On balance they said they thought it was the most sensible thing to do with it. If you put it in the National Health Service they felt it would work with some reorganisation, but whatever major changes one makes, there is going to be quite a large amount of reorganisation. So we are actually going for what we think will work.

(Dr *Taylor.)* We felt a special body would tend to keep people in the prison system who were mentally ill who should really be outside the prison system and who would, in the longer term, probably not be fitted into patterns of community care, which they would do if they were being treated by the NHS.

753. Another point that is not quite clear from your proposals, as we read it, is: do I understand it from you that there would then be no full-time prison medical officers? Are you taking into account the amount of report work that has to be done? Do you believe all this could be done by doctors coming in from outside? I was thinking not just for the courts, which is, particularly in the remand prisons, pretty heavy, but also for organisations like the Parole Board.

(Mr *Rutherford.)* That is our general view. There might be variety of arrangements within such a scheme that would allow people to work on a full time basis but they would not be employed by the Home Office. Their arrangements would be at a local level.

(Ms *Crook.)* One of the points we want to make very strongly is that we are here to campaign, to get a reduction in the prison

[Chairman *Contd.*]

population. One of the ways that can be done is not to remand so many people for reports, which can be done in the community. So to a certain extent a part of our evidence is our saying that a lot of the people held on remand in custody should not be there, that those psychiatric reports and other kinds of reports should be done in the community, that that would actually lessen some of the necessity for having prison doctors.

754. To get it quite clear, what you are suggesting is if the Family Practitioners' Service had this total responsibility, then magistrates would have more confidence in allowing people on bail who required psychiatric reports?

*(*Ms *Crook.)* Hopefully; that is one of the ways of putting it; it was not the way round I was putting it, but, yes.

755. I thought you were implying that; is that not right?

*(*Ms *Crook.)* We say both ways, that we have got a lot of people employed in the Prison Medical Service, doing reports on people who are held in custody who should not be in custody. So what we are saying at the moment is if we can get a few of these people out, those reports can be done in the community.

756. Surely there are two categories. There is pre-trial, those on remand, and then there are those who have been convicted. They are actually different categories, are they not?

*(*Ms *Crook.)* Yes.

*(*Mr *Rutherford.)* Yes, but with particular reference to the group of people held awaiting reports for court, in a sense the prison becomes a very convenient dumping place, that people are remanded in custody for reports of one sort or another; it might be for social inquiry reports; it might also be for medical reports. We feel the burden of our case is that more people would be remanded on bail for such inquiries to be made.

*(*Dr *Taylor.)* One of the advantages of this would be that many more NHS consultant psychiatrists would be involved who are, surely, I would have thought, the most appropriate people to be writing psychiatric reports. It would have the advantage, not only of their expertise, but from local catchment areas they would be coming in to see and report on prisoners and have practical knowledge of what was available and be stimulated to help try to provide th in the community in local hospitals.

Mr Kennedy

757. Moving on to another point yo make; you very strongly make the point th doctors should not be involved in priso management, and you quote categorical in point 4.5 that you think the kind of ro for doctors within prison has a very ba effect on the patient/doctor relationshi What is the thrust of your justification f that and do you not see some advantage having some kind of medical input into, you like, the decision-making process in t running of the prison which, of cours could be to the advantage of the prisone themselves?

*(*Mr *Rutherford.)* I think, as Dr Tayl was saying, we are very concerned improve, not only the quality of medic and health care within prisons, but improve the quality of the doctor/patie relationship. We feel strongly that tha relationship is put on a problematic basis b the doctor being involved on the sort o official management structure. We certain believe that doctors, nurses and others ca have a profound impact for the good withi prisons; that their presence within the pr son can and should be very considerabl but that will be enhanced by their indepen dence from the prison management.

758. Is that not wanting it both ways?

*(*Mr *Rutherford.)* I do not think so. I thin their situation as at present, as a member o the Prison Medical Service, is one that compromised by their position within th management structure. We would hope b freeing them from that, simply by bringin in more people from outside, the impact o the doctors and nurses on the way in whic prisons are run would be very much bett than it is now.

Chairman

759. Following that up, how would yo see administratively you would cope wit the problems you put in paragraph 1. when you draw attention very properly t hiding problems? Do you not think thes might be even worse than they are if ther was no doctor around the place perma nently. Do you think the visiting docto would be so horrified it would have mor force?

*(*Mr *Rutherford.)* I ought to make clea we are certainly not expecting that th

[Chairman *Contd.*]

result of our recommendations would be a reduction in the number of doctors around the place, either on a permanent or part-time basis. We are not arguing for that for one moment. Our hope would be that with doctors coming in, if you like from the outside, and they might be coming in quite a large proportion of their working days in some cases, that their horror and anger at some of the conditions that they see would be for the good, that they would be able to speak out in public on things that they see that concern them. As you will see elsewhere in the evidence, we draw attention to the negative impact of the Official Secrets Act. I think this is particularly important with reference to doctors and in prisons. We have not had a tradition of prison medical officers speaking out in this country on matters of great public concern. I think we would hope one of the results of moving along the lines that we are recommending would be for just that, doctors and nurses who have a very profound effect for the good.

Mr Kennedy

760. I would like to come on to that very point. Could I quickly ask you a follow up question? You do say in point 2.3: "The prison medical service is widely considered to be low status, low paid and with very poor career prospects". You use the phrase in fact, "dead end" as well and say that many of the doctors are over 55 years old. How much do you attribute the problem of doctor/patient relationship in terms of management of prison to those factors rather than simply the extent of such an issue of the doctor being involved in the management itself. If we overcame those problems, would that go a long way to lessen the sort of difficulty you see?

*(*Dr *Taylor.)* I think it might lessen it to some degree. I think there is a good deal of professional isolation within the prison medical service which does not militate well for further training and keeping in touch with the latest developments in medical and psychiatric practice. I can only see that changing with greater impact from the outside service coming in and taking over. As far as I am aware, for instance, the Prison Medical Journal is not available outside the prison medical service. I think that reflects the attitude of the prison medical service. I think, to make it an interesting career, it is very difficult in the present structure.

761. On the Official Secrets Act, how realistic is it to say that it should not apply to penal institutions any longer, and are you suggesting no sense of security in that respect whatsoever?

*(*Mr *Rutherford.)* I think this obviously raises the broader question of Section II of the Official Secrets Act. Certainly from the perspective of the Howard League, we would say I think that the Official Secrets Act has not been a useful factor for improving prison conditions and raising issues that need to be raised about the way in which prisons are run. To narrow it to the question of health care within prisons, it comes back to the point being made earlier, that it is vitally important that doctors and other professionals who have access to prisons should be in a position to speak publicly about matters that concern them, so that these issues can be fully aired in the public domain. It is one example of where the Official Secrets Act is probably something that works against the interests of running prisons in a decent and humane way.

Mr Galley

762. Sir David referred to your comments in Section 1.5 where you do say quite strongly that the quality of the health care is below the standard of health care in the community. One can readily see that the health environment is poor in view of the appalling sanitary conditions and the overcrowding and so on. How much hard evidence do you have that the actual standard of the care is lower?

*(*Mr *Rutherford.)* I think we qualify it there by saying "often below". We are not making it a general statement, nor are we, I should emphasise, casting judgment on the quality of many of the people working as doctors and nurses in the prison system, but, as a general rule, an important feature of the prison situation, of course, is the absence of choice which we do refer to in our recommendations. We are saying that by integration of the health service at least there is an opportunity for choice. It is, as we mentioned earlier, despite what I was saying about the fact there are some very good people working in the prison service, known as a service that is not typified by the very best in terms of medical qualifications and medical experience. There are people working in prisons who, one has to say, are not highly regarded by all their colleagues. We are saying in that sort of situation choice becomes even more imperative, and

[Mr Galley *Contd.*]

that we would hope by moving in the sort of direction that we recommend, some improvements of that sort would be made.

763. I can understand and share with you a feeling that health care in prisons may well be less than in the community at large, but you make a fairly strong statement in this paper. Have you got any specific evidence that that is the case, because there is a degree of readiness of access to doctors, a high level of numbers of consultations or the doctor who is there on the spot to give the service throughout much of the day.

*(*Dr *Taylor.)* I think perhaps I can give an example of, say, the mentally ill person in prison who is perhaps unaware that he is ill but cannot be treated against his will on remand. It takes quite a long time to arrange hospital treatment outside the system and they may well go for months at a time without the sort of health care that they would get if they were in the community outside prison.

764. What about the physical health care?

*(*Mr *Rutherford.)* It is a difficult situation to specify in quantitative terms because there has not been the sort of empirical research that you ask about. There have not been studies of a comparative nature. One does know, and I speak now as a former deputy governor working in the prison system, that there are those doctors working in prisons who are extremely unsympathetic to what they have described as malingerers, people who have complaints.

Mr Winterton

765. It is not unique to prisons?

*(*Mr *Rutherford.)* No.

766. So why should prisons be any different from the treatment that people get out in the community?

*(*Mr *Rutherford.)* It comes back to my question of choice. If the prison hospital, the prison doctor, and his hospital officers, have decided that certain categories of people, certain individuals, are malingerers, are taking advantage, are trying to get out of a work situation or something, it is then extremely difficult for that particular person to pursue their complaint which may in some cases be something which should be taken rather more seriously than it is. All I am drawing attention to is the absence of choice within the prison situation. That provides, I think, a special onus on openir it up in the way that the Howard Leagu has recommended.

Mr Galley

767. Are you suggesting the procedure vetting requests to see the doctor is inimic to good health?

*(*Mr *Rutherford.)* All I am saying is in situation where the patient, the prisoner i this case, who could be as young as fourtee years old, or the person on remand, ha confidence in the doctor as a professiona who has the sense that at least they have g a possibility of choice of getting som second opinion, is able to feel that the particular situation is being listened t sympathetically, you have got at least th beginnings of a sort of decent doctor patient relationship. I think that is ver often missing in the prison situation at th present time.

*(*Ms *Crook.)* On the quality of healt care, may I say something on nursing staff We recommend that all nursing staff shoul be NHS trained fully and should retai membership of their professional associa tion or trade union, and not be mixed up i the control/discipline side, with the carin side. I think that has been a problem so fa that nursing staff in a lot of penal institu tions have not been fully trained and tha will affect the quality of their care. It i bound to do that as well as causing confu sion between discipline and control. I thin the point has been made about prisoner being able to complain; that is importan That is another spin-off of being integrate into the local organisation of the NHS They would be able to have access theoreti cally to the community health council which are the watch dogs of health car within the community. That could also b true for people in penal institutions.

Mr Winterton

768. Could I press you actually on th matter of the problems that you thin prisoners have in complaining? They cer tainly never hesitate to write to Members o Parliament, you know. So they do hav access to people who can raise matters or their behalf. Would you not say that wa acceptable?

*(*Ms *Crook.)* I think that is a check an some of them do write to Members o Parliament; a lot do not; some are fright ened to do so; some perhaps cannot write o express themselves as well as they woul

Mr Winterton *Contd.*]

ike. I think they should have access to the tructure of the National Health Service, he same as the rest of the community.

769. Would you not say that out in the ommunity—and this leads me on to the uestion I was wanting to put to you—there re many people who may be drug addicts, vho may be alcoholics, who do not have a loctor of their own, a general practitioner, ecause they are, of course, homeless, and nany of these people end up in prison, and herefore perhaps they are rather better off n prison, where medical and psychiatric are is available to them, than they may be utside? Outside they are on nobody's anel. Therefore perhaps all of you might ike to attend to this question, because I am uoting from paragraph 4.3 of your evi- lence, where you say that there should not e special treatment centres for drug addicts r alcoholics inside prison and that this —and I am using your words—would only ncourage their being sent to prison. I put to ou: is there not a danger that taking such a lefinite, absolutist view of this kind, which s very much what your evidence is about, ust allows the Home Office on the one and to do nothing at all for these particu- ar prisoners. Are there not also many risoners who do have a drug or alcohol roblem but whose crime is not as a result f dependency and so should not arguably e let off a prison sentence? Would they not enefit from such treatment centres within he prison?

*(*Mr *Rutherford.)* It is obviously a di- lemma there. Essentially the thrust of our evidence is hopefully to point a way out of the spiralling nonsense that we have got ourselves into in this country. Here we are locking up more head of population than all but five other members of the EEC, essen- tially dealing with people who do not pose a serious threat to others, who in many cases are petty property offenders who are placed in prison because the courts cannot think of anything else to do with them. Prison becomes a sort of convenient dumping place, an option to the health service. We are saying that we really do need to try to reverse these priorities and that if there has to be some give, perhaps that is where it should be giving, that the prison essentially should be seen as a place that holds persons either on remand or convicted, for serious offences, that there should not be a tempta- tion on the part of the courts, on the part of the hospitals, nurses and doctors working in regular hospitals, to see the prisons as a convenient receptacle for people who, if you like, provide nuisance.

770. Could I not press you, Mr Ruther- ford. You are absolutist in this particular paragraph 4.3 of your evidence, and you say that there should not be special treatment centres for drug addicts or alcoholics within prison. Do you not believe that is going too far and that there could be such centres within prisons because they would be most desirable for the treatment of those who have committed offences but not as a result of their addiction, either to drugs or to alcohol?

*(*Mr *Rutherford.)* I think, Mr Winterton, you have carefully put your finger on a dilemma, as I say. We are certainly not saying that within the prison situation initiatives should not be taken to work with people with particular medical problems or problems of another nature. What we are concerned about is the danger of particular treatment units being set up and advertised as having a specialist role to play which then provides an easy out for the courts faced with tough choices and for hospitals and for others.

771. Can I then ask your colleague, Dr Taylor, whether he would in fact support those of us in the House and on this Committee who are deeply concerned about the effects of the care in the commu- nity philosophy which is, in fact, ensuring that our prisons are being more heavily occupied by people who should more ap- propriately be treated in hospital, as prob- ably many of them are who have come out of psychiatric hospitals in the first place, rather than in prisons, because of the reduction in places in psychiatric hospitals and the reluctance of some such hospitals to take these people back again?

*(*Dr *Taylor.)* Yes, I go along with that view, and particularly in relation to the regional secure units which are mentioned in paragraph 4.4. I think there has been an expectation that these units will somehow relieve the prison service of a vast number of the mentally ill. They clearly will not. One of the reasons why I am keen on the notion of local area NHS consultants com- ing into prisons is that they will be much more aware of their responsibilities to the non-dangerous offenders and one would hope therefore be more inclined to make facilities available to them. There should be great encouragement to the NHS general psychiatric hospitals to make provision for

[Mr Winterton *Contd.*]

the sorts of patients that they are not getting now because they do not wish to be embarrassed by patients who, for instance, merely abscond, and that sort of patient. Certainly the regional secure units are not the entire answer. I think the general psychiatric hospitals must be much more involved.

772. Are you concerned yourself about the reduction in places in these hospitals, the failure to provide any alternative accommodation, that is with sufficient beds, hostels or other such accommodation with appropriate facilities? People are discharged into the community and many of them become people who drift into prison through alcohol, through drug offences?

*(*Dr *Taylor.* Yes, indeed.

773. May I quickly ask this of Frances Crook? She raised a matter I wanted to ask about. I would like to clarify the position. She stated she would like to see the nursing staff in prisons as part of the NHS and members of the various nursing organisations or trade unions. Do you not see any problems with security where that is concerned? Would you not go along with me in thinking that a better way of achieving that objective would be to try to ensure that many more members of the prison hospital service did in fact achieve NHS nursing qualifications, SRN.

*(*Ms *Crook.)* No, because I do see a conflict, I am afraid, between the control discipline side and the caring side of the nurses' vocation and duties. I think they should be split up. I do not think that there is necessarily any conflict with security because I am not saying there should not be prison officers there that could lessen security in any way. So I do not think there is a problem there.

Mr Yeo

774. I was not quite clear from one of your earlier answers to Mr Winterton whether you were also saying there should be no specialist unit for mentally ill people in prison as well. Was that the implication of what you were saying?

*(*Mr *Rutherford.)* I do not want to underline this point too much. The essential thrust of what we are trying to say here is that we do not want the prison to become and be continuously used as a convenient dumping place as has been in the past up until now. Certainly within the prison situation one would hope that creative and therapeutic opportunities will arise without necessarily calling them special treatme units. Sometimes these initiatives are tak by uniformed prison staff. Sometimes the are initiatives that are taken by prisoner Sometimes these initiatives are taken l professionals. They are certainly not in th exclusive province of the professionals. O would hope that there would be a variety initiatives of this sort. The newly reopene unit at Parkhurst Prison is clearly a example of perhaps the sort of unit that yo are mentioning. One can see a role of th sort. What we are really trying to do is state the emphasis of where the poli thrust should be; that is, to try to say th prisons should be used much less frequent and should be targetted upon serious offe ders.

775. I notice you quote in your par graph 1.3 from a publication called 'U lawful Sex' which I am afraid is not one am familiar with personally. I wondere whether really you would agree that wha we ought to be trying to do is to giv remand prisoners a greater chance of pro per assessment and the possibilities of bein recommended for treatment and the exis tence of these special units might be a wa of doing that under certain circumstances

*(*Mr *Rutherford.)* Yes, the "Unlawfu Sex" report was published on behalf of th Howard League last year. The Secretar was Professor West, who as you know wa Professor of Clinical Criminology at th University of Cambridge. He and his tean of colleagues reached the view that b making much more use of the remand i the community, rather than remand i prison, people would become aware c options that would not otherwise occur t them. The prison medical service, simpl because of its location, tends to be s blinkered as to what the options might be i the community. A variety of new ways c holding onto people in the communit becomes evident by avoiding the remand i custody situation in the first place.

Chairman

776. You believe in that context th establishment of the remand centre run by professional service would help?

*(*Mr *Rutherford.)* Of bail hostels, cer tainly, absolutely, very strongly indeed. If could just say, the concern that we felt i putting this evidence together very much arises from what we feel is a very unfortu nate general policy thrust towards th expansion of the prison system in thi

Chairman *Contd.*]

country and to add another 10,000 cells at this time, to be planning for a prison population that is even larger than the one we have at the present time, has terrible costs, not only costs in a broad sense to us living in a free society, but costs that might well be spent in terms of developing options in the community. It also has an important cost in terms of actually reducing the quality of life in prison because money that might be spent on maintaining decent standards in prisons at the present time is being devoted towards capital expenditure. These are concerns which we hope are reflected in the evidence we are giving.

777. Even if we could as a society get down the prison population, do we not need a good deal of capital expenditure to make many of our prisons at least tolerable, the three in a cell and all that we hear? Surely even with a reduced prison population quite a lot has to be spent anyway?

*(*Mr *Rutherford.)* That is rather less than we think. This is perhaps taking us into broader territory. The position of the Howard League is strongly in favour of a freeze on prison construction. We feel the prison population could be very substantially reduced and we would want to question very seriously indeed the building of any further prisons.

Chairman: I think that would take us rather further than our remit on this committee. Mr Rutherford, and your colleagues, thank you very much indeed for coming and giving us evidence. As I said at the beginning, a lot of the things in your memorandum we have not questioned you about. We have these points in mind. Thank you very much.

Memorandum submitted by the National Association for the Care and Rehabilitation of Offenders

I: INTRODUCTION

A national prison medical service was introduced in England and Wales in 1878, and this service continued as a separate autonomous service when the National Health Service came into existence in 1948.

Every penal establishment has its own "hospital" which provides facilities for the treatment of the ambulant sick and for the routine treatment of bed patients who do not require detailed investigation or professionally skilled nursing. More elaborate facilities are generally available at the larger establishments to which prisoners may be transferred, and there are fully equipped surgical theatres at Liverpool, Parkhurst and Wormwood Scrubs (though the latter is currently out of commission during the rebuilding of the prison).

Each establishment has either a full time managing medical officer (who may be a basic grade medical officer, a senior medical officer or a principal medical officer) or a part time medical officer who will usually be a local general practitioner contracted to devote a minimum number of hours each week to prison duties. On 31st December 1984, 94 full time medical officers (all grades excluding headquarters posts) were in post, as were 97 part time medical officers. About half the full time medical staff have post-graduate qualifications in psychiatry.

Additional medical and paramedical support is provided by visiting practitioners in a variety of specialties, over 120 of whom are employed on a sessional basis. The largest group comprises visiting psychiatrists, but there are also consultant physicians, venereologists, gynaecologists (in the female establishments) and, for the surgical units, general orthopaedic, ENT, plastic and ophthalmic surgeons and anaesthetists. In addition, prison medical staff may arrange for the attendance of a consultant of any specialty to assist in a particular case. It is therefore possible for prisoners to gain access to specialists more quickly than by going through an outside G.P. and hospital out-patient system.

The medical officers in the male establishments are assisted by hospital officers. These are uniformed prison officers who have received training at one of the prison service's

hospital officer training schools. Only about 10 per cent hold nursing qualifications and a but two are male. However, nurses (all but one of whom are female) are employed i establishments for women and at the establishments which have surgical units. On 31 December 1984, there were 860 hospital officers in post and 158 posts were vacant. Th corresponding figures for nurses were 148 and 45.

The prison medical service has four main functions:

(i) *Care of the physically ill.* This involves the examination of inmates on reception an discharge, the examination of prisoners who report sick and the medical treatmer of prisoners.

(ii) *Health, hygiene and advice to management.* The medical officer is expected to advis on matters affecting the health and hygiene of the establishment, including livin and working conditions, sanitation, ventilation, working arrangements, diet an clothing.

(iii) *The preparation of reports on prisoners* for courts, the Home Office and in connectio with parole.

(iv) *Psychiatric work.* Psychiatric assessment is an essential element of report writing, bu in addition there is a continuing need for diagnosis, including consideration c whether a prisoner should be transferred to a psychiatric hospital under th provisions of mental health legislation and of prisoners who show some menta abnormality which is not such as to justify transfer to hospital and require treatmer in prison.

The Director of Prison Medical Services is responsible to the Director General of th Prison Service for the provision of medical and nursing services and for providing advice t the Prison Department and other divisions of the Home Office on all matters affecting th health of prisoners. He is assisted by a Medical Directorate. There is also a Deputy Directc of principal medical officer rank and three other principal medical officers whose duties ar largely regionally determined.

During 1983 medical attention was sought by prisoners on 1,354,561 occasions, a increase of 73,137 over 1982. Admissions to prison hospitals for observation or treatmen numbered 41,524 compared with 43,636 during the previous year. The average dail number of patients in these hospitals was 1,319—about the same as in 1982. The tota number of hospital beds available was 2,536, of which 52 per cent were occupie throughout the year. 1,071 patients were transferred for treatment or investigation t establishments with more extensive medical facilities, compared with 962 in 1982.

II. PROBLEMS OF THE PRISON MEDICAL SERVICE

Later in this submission, we will argue that the prison medical service should be brough under the auspices of the National Health Service. First, however, we will examine in turn a number of key problems which illustrate the difficulties of the present position and wil make a series of specific recommendations which could usefully be carried out in the shor term while legislation to effect more fundamental change is being prepared.

(i) Prison medical officers: recruitment and professional isolation

In the past, there have been considerable problems of recruitment to the prison medica service. In 1978, in its evidence to the May Committee of Inquiry into the United Kingdon Prison Services, the Home Office said:

> "For several years now, the majority of the larger establishments have failed to enjoy their full complement of medical staff and in a number of instances such establishments have had to be kept running at, or even under, half strength. Most M.Os. are having to perform more duties and are 'on call' more frequently than they used to be. The greatest increase in their work has been of the routine, mundane, but nevertheless important type (e.g. routine examination on reception or discharge) and they find that they no longer have sufficient time for tasks which make their jobs more interesting. It has become almost impossible for them to

attend professional courses of instruction in order to acquire further experience or gain higher qualifications, as they cannot be spared from their duties".

In its report, published in 1979, the May Committee recommended that "an urgent eview should be initiated of what should be done to encourage more and better qualified octors to join the prison medical service".

Since then, however, there has been an improvement in the position. On 31st December 983, 77 full time medical officers (all grades excluding headquarters posts) were in post: ne number of approved posts was 99. On the same date, 96 part time medical officers were 1 post, while 18 such posts were vacant. In comparison, by 31st December 1984 the umber of full time medical officers had increased to 94 (approved staffing level 102). On ne same date 97 part time medical officers were in post and 17 part time posts were vacant. Whereas the Home Office told the May Committee in 1978 that it was "almost impossible" or medical officers to be spared for further training, in the year ending 31st March 1985 30 ull time medical officers attended 45 external courses.

In his book, "Prison Health Care" (British Medical Association, 1984), Dr. Richard mith saw the problem as follows:

> "Recruitment has been a problem for many years in England and Wales, and it is a problem, too, in other prison systems around the world. It would perhaps be surprising if it were not so: a full time career in prison is unlikely to be at the top of any young doctor's list of career options. Part time work is quite different, and many doctors are interested in this option. This is another argument for more integration with the N.H.S. and a greater use of part time doctors".

However, the recent improvement in recruiting has been almost entirely in relation to ull time posts, whereas the number of vacant part time posts is little better than at the end f 1983.

In its evidence to the May Committee, the Home Office acknowledged that mprovements in pay and conditions might have an effect on recruitment, stating:

> "While other factors (including the working environment and the image of the prison service) must play a part, it is entirely possible that current levels of pay and conditions of service are not sufficient to attract candidates of the right calibre in sufficient numbers".

Prison medical officers argue that their salaries are not competitive with general practice; nat pension arrangements are inequitable in comparison with those for N.H.S. yschiatrists; and that their work and conditions are more exacting than those of the other nembers of the civil service medical officer grade (e.g. in D.H.S.S. headquarters) because f the regular 24 hour "on call" commitment and the working environment. The latter onsideration is recognised in principle by the environment allowance paid to prison nedical officers, although at its present level (£450) it can hardly be of much significance vhen recruiting.

In its evidence to the May Committee, the Royal College of Psychiatrists argued that the rison medical service was "isolated within the medical profession", and also pointed out nat medical officers' working environment is poor; that their clinical practice is restricted rgely to males of one socio-economic group (almost 95 per cent of British prisoners are nales aged between 14 and 50); and that full time medical officers do not work outside risons, follow up their prisoner-patients into the community or become involved in work vith families.

The danger of professional isolation was also noted by Dr. J.A.C. MacKeith, consultant orensic psychiatrist with South East Thames regional health authority and a former nedical officer in Brixton prison, in an address to a conference on medical services for risoners held by the Kings Fund Centre and the Howard League for Penal Reform in 978. While he did not advocate fusion of the prison medical service within the N.H.S., he nought that benefits would be likely to follow if prison medical officers were more nvolved with the larger medical community. In his view, ill-informed and unconstructive

criticism from doctors outside the prison service was facilitated by the ignorance whic most doctors had of practitioners in the prison medical service and their work. H commented:

> "I suggest that the medical officer may become so over-specialised in this field that he begins to feel that he is after some years' service unqualified to work outside the prison medical service. I doubt that this can be a healthy development as reduced professional self-esteem and confidence could follow. A proportion of his time spent working in an N.H.S. setting could help to increase the movement of doctors in and out of the prison medical service. Benefits flowing from this might include an improvement in the integration of prison and health service facilities which deal with the same offender patient as he passes backwards and forwards between the community, hospitals and the prisons".

In response to criticisms of the isolation of the prison medical service, the Home Offic points to the extensive interchange and co-operation which exists between the service an the N.H.S. During 1983, prisoners attended the out-patient departments of N.H.S hospitals on 17,685 occasions and 1,634 prisoners were admitted to N.H.S. hospitals for in patient treatment. N.H.S. general practitioners act as the medical officers responsible fo the provision of medical services at smaller establishments and, at most of the large establishments, N.H.S. general practitioners assist the full time medical officers. A larg number of specialists—most of whom hold appointments in the N.H.S.—visit establish ments on a regular basis, including dental surgeons, opticians, venereologists, psychiatrist and psychotherapists. In addition, a range of N.H.S. consultants visit establishments t meet the needs of prisoners in particular cases, including psychiatrists, surgeons an physicians. In 1983, some 98,155 prisoners were referred to visiting specialists an consultants: 62 per cent of these saw dental surgeons, while the majority of the remainde saw opticians, venereologists and psychiatrists.

It is estimated that about two-thirds of all the medical work done in prison departmen establishments is carried out by doctors whose principal employment is the Nationa Health Service. The Report on the Work of the Prison Department for 1983 commented

> "This substantial degree of 'functional integration' with the National Health Service ensures that full time prison medical staff do not become isolated from their colleagues in the community and that the full range of National Health Service facilities is accessible to inmate patients".

The Home Office also argues that, insofar as such isolation exists, it is doubtful whethe it would be ended by an administrative incorporation of the prison medical service in th N.H.S., since there would still be a need for doctors to be employed full time in the large establishments and it is doubtful whether a change of employer would greatly alter an feeling they may have of separation from the medical profession outside.

It suggests too that amalgamation with the National Health Service would not of itsel produce more doctors who wished to undertake work of this nature; that the number o doctors who wish to practice their profession in the service of prisoners is likely to b limited, whatever the formal arrangements for their employment; and that, even i psychiatric posts in prisons were filled by N.H.S. recruitment on N.H.S. terms, they woul presumably still attract applications only from those interested in working with offenders i a prison setting. In our view, these arguments underestimate the psychological importanc which the employment of prison doctors by the N.H.S. would have both for their ow perception of their role and for that held by doctors working outside prisons.

However, the Home Office acknowledges the desirability of developing opportunities fo further training and attachments between the prison medical service and N.H.S. specia hospitals: in 1982 it reintroduced a scheme of short term attachments to these hospital which had previously operated successfully from 1965 to 1975. Medical officers have also been encouraged to offer training experience in prison establishments to senior registrars i forensic psychiatry.

Pending arrangements to bring the prison medical service under the auspices of the National Health Service, *we recommend that:*

(a) *There should be increased opportunities for prison medical officers to attend courses of further training, to spend part of their time working in an outside N.H.S. setting and for attachments between the prison medical service and the National Health Service.*
(b) *There should be a review of the level of the "environment allowance" to assess how far it is realistic as a way of compensating medical officers for the nature of medical work in prison.*

(ii) The training, qualifications and recruitment of prison hospital officers

In the N.H.S., a state enrolled nurse has two years' training and a state registered nurse has three years. In contrast, prison hospital officers receive 24 weeks' introductory training, and until 1983 it was only 13 weeks. The position is different in Scotland, where prisoners are looked after by nursing officers. These are discipline officers who have completed 18 months' training, most of which takes place outside the prison. The course is organised and examined by nursing bodies independent of the Scottish prison medical service. Both the Canadian and United States federal prison systems have fully trained nurses.

Considerable concern has been expressed about the adequacy of hospital officers' training in relation to the tasks which they have to perform. For example, they administer drugs whereas the usual rule in the N.H.S. is that only a qualified nurse may administer drugs while another acts as witness. The Society of Radiographers has expressed concern that radiography is undertaken in prisons by hospital officers who do not possess the training and qualifications which are necessary in the N.H.S.

A further example came to light in the report of the inquiry by the Regional Director of Prisons for the South East Region into the disturbance in D Wing of Wormwood Scrubs on 31st August 1979. The report, published in 1982, stated:

> "The duty medical officer was aware that hospital officers were suturing wounds received by prisoners and was content that this should continue, particularly as it did not mark a departure from normal practice at Wormwood Scrubs . . . Nineteen prisoners required sutures, all for head wounds" (para. 74).

It is quite unacceptable that such stitching should be carried out by hospital officers without nursing qualifications, particularly since the prisoners had not first been seen by a doctor, given that the scalp wounds indicated head injuries and that the prisoners might have damage to the skull or to the nervous system. This is completely at variance with practice in the National Health Service, where such stitching would only be done after a patient had been examined by a doctor who had then authorised a qualified nurse to carry it out.

More recently, Dr. Benjamin Lee, who was formerly a member of the Prisons Inspectorate, wrote in the "Lancet" in 1983:

> "There was no doubt in my mind that some hospital officers did take on, or were entrusted with, medical responsibilities far greater than was warranted by their training, knowledge, experience, or aptitude" (p. 1268).

Both the Prison Officers' Association and the Royal College of Nursing have argued that the nature and extent of training for hospital officers is inadequate. The argument that prison hospitals are more akin to "sick bays" than hospitals, as prisoners who are seriously ill are normally transferred to the N.H.S., has some force; but the number of prisoners with mental problems and the nature of some tasks undertaken by hospital officers make the case for a better trained staff an overwhelming one.

The report of the Chief Inspector of Prisons on H.M. Prison, Birmingham, published in 1982, stated that during the inspection some hospital officers had expressed an interest in obtaining formal qualifications such as S.E.N. and R.M.N., but felt a lack of encouragement. The Inspectorate team considered that many staff were experienced at dealing with mentally unstable, disruptive and even violent prisoners held in the hospital

while on remand for mental observation for the preparation of reports to court. Althoug these staff had acquired through their work skills which were extremely valuable, the skill would not be recognised outside the service, because the staff concerned held no officia qualifications. The Inspectorate felt that this was "unfortunate because other professional would underestimate the contribution which hospital officers were able to make whe dealing with people of this kind, and because the public's attitude to the hospital officers work would be based upon a misunderstanding of their abilities". It therefore supporte the staff's desire to obtain qualifications and hoped that the Prison Department would b able to find some means of arranging this.

The Chief Inspector also recommended that all hospital staff at the prison below the ranl of principal officer should receive at least two weeks' training by attachment to N.H.S general hospitals or mental hospitals each year. In response, the Home Secretary observe that this recommendation "has implications throughout the prison service", and added:

> "Arrangements for hospital officers to be attached to N.H.S. hospitals for short periods later in their careers are made locally with encouragement from headquarters. We should like more such arrangements to be made but, unfortunately, the scope is hampered by the limits on staff resources which mean that it is sometimes difficult for officers to be spared from their normal duties".

Traditionally, hospital officers have been recruited from those who joined the service a discipline officers and, after completing twelve months' service in that capacity volunteered for training as hospital officers. By the end of 1983, the Prison Department hac concluded that the traditional method of recruitment was unlikely to yield sufficien recruits in the foreseeable future to meet the demands being placed on the hospital office service. Moreover, the traditional method would not be capable of raising the proportio (currently of the order of 10 per cent) of hospital officers with nursing qualifications, whic the Report on the Work of the Prison Department for 1983 described as "anothe important objective of the Medical Directorate".

In an endeavour to remedy these deficiencies, it was decided to advertise in the nursing press inviting registered general nurses and registered mental nurses to apply to becom hospital officers. This was the first time the Department had mounted a campaign specifically to recruit hospital officers, and the first time that qualified nurses had beer made a specific target for recruitment to the hospital officer service. We understand that the campaign proved successful, and that similar campaigns will be run in the future in paralle with the traditional trawls among serving prison officers. The aim is to increase the proportion of hospital officers who possess nursing qualifications to about 30 per cent.

We recommend that:

(i) *There should be greater opportunities for prison hospital officers to acquire training and obtain qualifications.*

(ii) *A much higher proportion of hospital officers should possess nursing qualifications, and attempts to recruit staff direct from the nursing profession should be continued and intensified.*

(iii) Safeguards for patients

The Report on the work of the Prison Department for 1981 described the current safeguards for prisoner-patients as follows:

> "Under the present arrangements the Home Secretary is accountable to Parliament for the provision of medical services in establishments, except where matters of clinical judgement are involved. The prison medical service is subject to a system of supervision by management and inspection by the Inspectorate of Prisons. There are a number of channels through which prisoners may raise complaints about their medical treatment for investigation and these include the Parliamentary Commissioner for Administration. If the prison medical service were incorporated into the National Health Service it would not be possible to devise arrangements by which there would be the same degree of central control

over and ministerial accountability for medical services in establishments. As a person in a prison establishment could not, in practice, have the freedom of choice of medical services that is available to a person at liberty, the present system of control and accountability provides an essential safeguard for those in custody" (para. 243).

However, none of the normal channels for internal prison complaints are specifically medical in nature. The limitations which this imposes were illustrated in the Home Office funded research study, "The 'Watchdog' Role of Boards of Visitors" by Mike Maguire and Jon Vagg (1984). In a sample of 301 applications to Boards of Visitors in three prisons, 51 (17 per cent) concerned medical treatment. These included several objections to routine decisions which fall within the province of the medical officer, such as the issue of special footwear, and also a substantial number of direct complaints about treatment. Typical complaints were that prison doctors had changed prescriptions or treatments which prisoners had been using before their imprisonment; that only a cursory examination had been made when the applicant reported sick, or that no treatment had been given for what the complainant regarded as quite a serious medical problem. The researchers commented:

> "Medical problems are a headache for Boards because it is very difficult for them as laymen to question the uses of medication, the necessity for treatment, and so on, from the point of view of their own expertise.; but more importantly, because medical staff are often not willing to submit their professional judgement to lay examination".

When Boards felt that a complaint might be well-founded, with a tactful approach some doctors were prepared to justify their actions to Board members. However,

> "... there were other prisons in which members felt that such questions in person would not have been welcome, and the Boards concerned tended to do no more than record the complaints and hope that it would provoke some response".

In comparison, if an N.H.S. patient is dissatisfied with his treatment, he has various *medical* avenues of complaint—to District and Regional Health Authorities, Family Practitioner Committees, Community Health Councils, and the Health Service Ombudsman—none of which have any standing in relation to the prison medical service. Moreover, the Royal College of Psychiatrists pointed out in its evidence to the May Committee:

> "While psychiatric hospitals and units in the National Health Service are inspected and posts approved, for instance by the Royal College of Psychiatrists, the Joint Committee on Higher Psychiatric Training and the Health Advisory Service, psychiatric services in prisons are not subjected to the same degree of scrutiny"

The effectiveness and credibility of the safeguards for patients in prison is particlarly important because a prisoner cannot choose or change his doctor in the same way as an N.H.S. patient.

It has been suggested that prisoners dissatisfied with some major aspect of their treatment should have the right to an examination by an independent doctor of their choice. Most medical officers are resistant to this suggestion arguing that the medical officer, not the independent doctor, would continue to have statutory responsibility for the prisoner's health care; that the introduction of an outside doctor of the prisoner's choice would be an unfair imposition, which would amount to treating prison doctors as more suspect than those in the N.H.S.; that prison medical officers are encouraged to seek a second opinion of their own choice if there is any doubt in their mind about treatment; that it is the medical officer's responsibility, as it is the general practitioner's, to decide when a second opinion should be obtained; and that, even if an independent doctor recommended a different form of treatment, the prison medical officer would not alter the prisoner's treatment if he disagreed with the recommendation, and that he would be properly taking the decision in the exercise of his statutory responsibility.

There is little doubt, however, that the lack of any such right contributes to dissatisfaction by some prisoners and their relatives with their treatment and can help foster the impression that the service has something to hide. Many would feel that otherwise a

doctor should not be embarrassed by such a second opinion, but should rather find it helpful in assisting him to review his treatment.

If the prison medical service were brought under the auspices of the N.H.S., the normal range of medical channels of complaint would be open to prisoner-patients. In the meantime, however, *we recommend that one or more external and specifically medical avenues of complaint should be made available to prisoners dissatisfied with their medical treatment.*

(iv) Transfer of medical information and continuity of treatment

In his recent paper "The Prison Medical Service—last opportunity", a copy of which we understand has been submitted to the Committee, Dr. Maurice Rosen made a series of observations drawn from his work in the East End of London in the course of which he had treated thousands of homeless ex-prisoners. He commented:

> "The medical conditions they present with cover a wide range of conditions: psychiatric, alcoholism, drug addiction, chest diseases, and peptic ulcer, to name only a few. What surprises me as I see more and more who have been in prison who tell me they have received some treatment inside, is that I am very rarely contacted by the prison medical service to be asked what condition or treatment I had provided prior to my patients' sentence, nor, for that matter, what treatment they had received while serving their sentence so that I could continue with it if necessary. In fact the number of letters I have received over the years can still be counted on the fingers of both hands . . . I am led to understand that only those prisoners registered with a G.P. are given a letter on release—the rest are not. They therefore arrive back in surgery not having a clue as to what treatment they have received. Understandably this does not lead to prompt, or continuation of, treatment in all cases".

Dr. Rosen recommended that, on entering prison, all prisoners should be asked who their G.P. is or who was the last doctor they attended for treatment; that their G.P. should be contacted so that their past medical records might be obtained; and that all prisoners on release should be given a letter stating any medical conditions which have received treatment during their sentence.

We are also aware of instances in which sentencing courts have been unaware of a serious medical condition suffered by a prisoner while on remand in custody, and we have noted in this connection the comments in paragraph 22 of the Association of Chief Officers of Probation's submission to the Committee.

We recommend that procedures should be adopted to ensure that prisoners' past medical records are always obtained from their general practitioners, that steps are always taken to communicate information about their treatment in prison to doctors who may treat them on release, and that information about serious medical conditions suffered by remand prisoners is invariably communicated to sentencing courts.

(v) Provision for mentally disturbed prisoners

At any one time, the prisons contain a number of people suffering from mental disorder of a nature or degree which would satisfy the criteria in the Mental Health Act 1983 for compulsory detention in hospital for treatment. On 31st December 1984, there were 282 such prisoners, of whom 225 were diagnosed as suffering from mental illness, 48 from psychopathic disorder, seven from mental impairment and two from severe mental impairment. However, the usefulness of these figures is very limited in assessing the need for psychiatric care in prison, since there are many more prisoners who are clearly mentally disturbed and need psychiatric help but whose disorders do not fall within the Mental Health Act criteria. *We recommend that a detailed assessment should be carried out of the number of prisoners who require psychiatric care and of the nature of their mental disorders.*

While the physical conditions in prison hospitals are generally satisfactory, many members of the prison medical service agree that the gloomy corridors of cells which serve as "psychiatric wings" in such prisons as Brixton and Liverpool, together with their very limited opportunities for association or therapy, are quite unsuitable for holding mentally abnormal offenders. In addition, we have already referred in section (ii) above to the inadequacy of the training given to hospital officers caring for prisoners who are mentally disturbed.

Nor are Victorian-built male prisons the only ones in which facilities for mentally disturbed prisoners are seriously inadequate. Great concern has been expressed recently about C1 psychiatric unit at Holloway, the design of which makes it grossly unsuitable for prisoners with mental health problems. Its lack of natural light, low ceilings and drab colours result in a depressing and claustrophobic atmosphere. The design of the cells makes it difficult for staff to observe prisoners in their cells, and cell fittings can too easily be broken and used in suicide and self-mutilation attempts. Moreover, the Unit's regime is very restricted. The prisoners are frequently locked in their cells for a high proportion of the day and have very limited opportunities for education, training, recreation or other forms of occupation. (Following the recommendations of the Holloway Special Project Committee in its report published in July, the Home Secretary has announced a study into the feasibility of relocating the Unit in purpose built accommodation, and interim steps to improve conditions).

So far as prisoners falling within the Mental Health Act criteria are concerned, it is universally agreed that in principle such prisoners should not be in prison at all. The traditional stance of the Prison Department was spelled out clearly by Dennis Trevelyan, then Director-General of the Prison Service, in evidence to the House of Commons Expenditure Committee on 19th June 1978:

> "... we are in no doubt what the solution should be, which is that this type of person who has a history of mental illness, should be dealt with in the National Health system. Therefore, we do not think it is proper for us to make permanent provision within the prison service to deal with these people".

In recent years considerable efforts have been made by the Home Office and DHSS to get such mentally disordered offenders out of prisons and into N.H.S. hospitals. Nevertheless, courts and prisons continue to have difficulty in finding a hospital place for such offenders in all too many cases; in some cases offenders spend a period of time in prison before a transfer to the N.H.S. can be effected; and the mental illness of some offenders is not established or confirmed until they have been assessed during a period on remand in custody. Moreover, detention in an N.H.S. hospital under the Mental Health Act cannot be arranged for the considerable number of disturbed prisoners whose disorders do not fall within the Act's criteria. Therefore, while efforts to transfer mentally ill offenders to the N.H.S. should continue and be redoubled, in our view the prison system should also possess some facilities suitable for the care of disturbed prisoners.

The psychiatric assessment and treatment of prisoners from minority ethnic groups has been a particular cause of concern. Complaints made by black organisations include suggestions that some black offenders are unjustifiably diagnosed as mentally ill and given excessive medication. The Community Relations Commission's booklet, "Aspects of Mental Health in a Multi-Cultural Society" (1976), pointed out:

> "People suffering from mental illness may display widely varying symptoms depending on their background, although the underlying forms of their illness may be considered to be the same. Presentation of differing symptoms increases the ever present risk of mis-diagnosis and consequently of inappropriate treatment. It is also possible that certain behaviour of ethnic minority patients which may be considered abnormal in terms of Western European culture and life-styles may be seen to be unexceptional when looked at in relation to the patient's own culture".

Two factors were consided to be particularly important in increasing the risk of mis-diagnosis of people from minority ethnic groups—the first was language and communication and the second the person's cultural background. The booklet pointed out that black

doctors and social workers could help their white colleagues to appreciate such factors, ar this observation is of considerable potential relevance to the prison medical service.

We hope that the Committee will seek and carefully consider representations fro black organisations about this important area of concern.

We recommend that:

(i) *efforts to ensure that prisoners with disorders falling within Mental Health A criteria are catered for in N.H.S. hospitals should be continued and redoubled.*
(ii) *a psychiatric assessment and treatment centre, staffed by a multi-cultural team doctors, nurses and seconded probation officers, should be established within eac Prison Department region.*

III. INTEGRATION INTO THE NATIONAL HEALTH SERVICE

If the proposals which we have made above were put into effect, they could help t bring about significant improvements in the medical care of prisoners. However, w consider also that the fundamental step of integrating the prison medical service into th National Health Service should be taken as soon as possible.

We do not consider that this would provide a panacea for all the problems of th prison medical service: some of these problems relate more to the provision of medica care in a prison setting than to the auspices under which it is provided, and inadequat treatment is not unknown in the N.H.S. Nor should the degree of change which thi move would mean in practice be exaggerated. It has been suggested by some of thos who favour incorporation of the prison medical service in the N.H.S. that prisoner should have the right to choose their own G.P.s. from among those who service the are around the prison and, when a specialist is required, to see one of their own choosing However, prison medical officers quite reasonably express scepticism about the willing ness of G.Ps. to visit prisoners on request, pointing to the very limited circumstances i which G.Ps. are willing to undertake home visits. In its evidence to the May Committee the Home Office observed that some of those suggesting that medical care shoul become the responsibility of the N.H.S. saw this as ensuring that every prisoner woul have the right to treatment by a doctor of his own choice, but added that "of course, th prisoner would have to receive treatment from the general practitioner contracted t provide a service for the establishment in which he is placed".

Nevertheless, in our view such a move would help to some degree to improv recruitment, to reduce professional isolation and to promote the use of qualified nurses as well as giving prisoners access to external medical avenues of complaint.

Other considerations which are relevant to this issue include the following:

(i) The range and nature of medical officers' duties

The Report on the Work of the Prison Department for 1981 argued that "there ar many matters specifically affecting the physical and mental well being of inmates whic the National Health Service is not organised to meet" (para. 244). It pointed out that, ir addition to duties comparable to those of a G.P., a prison medical officer must:

(i) ascertain the health needs of all his patients as they come under, and when they leave, his care.
(ii) provide written reports to courts and for parole, and in some establishments regular review of life sentence prisoners.
(iii) interview and examine patients if they are charged with offences against prison discipline, when they go to court and when they return.
(iv) advise the Governor on a range of matters affecting the establishment as a whole, such as living and working conditions, hygiene, sanitation, clothing and bedding and the storing, preparation and serving of food.

In its evidence to the May Committee, the Home Office pointed out that, in discharging his responsibilities with respect to health and hygiene, the prison medical officer may from time to time consult a community physician or area medical officer. If general medical services were to be provided by the N.H.S., the question would arise whether these "public health" duties should be devolved entirely on to such people. The alternative, it suggested, would be to continue to employ full-time medical practitioners to deal with these aspects of institutional life. Indeed, the latter course might be necessary even if a responsibility for the public health aspects of prisons were placed with doctors in the community, because the Home Secretary "could not rely solely on inspection by outside agencies to ensure that his responsibilities for the welfare of prisoners were being discharged adequately in these respects".

For this reason, and because of the other functions listed above, the Home Office argued that there would remain a need for a full-time medical service, though on a smaller scale than at present, appointed by and answerable to the Home Secretary because of his responsibility for the proper functioning of the prison system. The Home Office concluded that "the prison system would in effect be served by two or more medical services, under separate administration, instead of one".

We do not regard these tortuous counter-arguments as convincing. The duties of inspection could and should be placed on local authorities and carried out by environmental health officers, and there is no valid reason why the remaining functions should not be performed by doctors employed by the N.H.S. working for all or part of their time in prison.

(ii) Adequacy of medical cover

In its evidence to the May Committee, the Home Office argued that uniformity of standards of health care was more likely to be achieved by a service which is subject to guidance and supervision by a central administration, and that there was a clear need for the Home Secretary, who is answerable to Parliament and the public for the welfare of prisoners, to be able to ensure that no establishment is left without adequate medical care. As their employer under civil service conditions of employment, the Home Secretary "is able to ensure that medical officers perform their duties adequately and is able to transfer medical officers from one establishment to another, temporarily or permanently, in order to ensure that medical cover is adequate". Since the Department of Health does not have similar powers in relation to the N.H.S., "standards of service may vary in different parts of the country according to the priority assigned to particular areas of health care by the area or regional health authority and their capacity to fill vacancies".

It argued that, if the prison medical service became part of the N.H.S. the flexibility of the present arrangements in respect of transfers of medical staff, deployment and use of resources between prisons would be lost.

However, in his book "Prison Crisis" (1980), Peter Evans, Home Affairs Correspondent of "The Times", took issue with the Home Office argument that posts in some prisons, being remote, would not attract doctors if they were transferred to the National Health Service, commenting:

> "National Health doctors already cover remote areas in general practice. The Home Office is at present not very good at attracting recruits. Pay is obviously a factor. If doctors were given a greater incentive to work in prisons, it would be more possible to attract recruits, whether the system were under the National Health Service or not".

(iii) The possible covering up of abuses

In recent years, public and medical concern about the prison medical service has largely revolved around the use of drugs in prison and certain well publicised instances of deaths in prison or soon after discharge. The attention which has been focussed on the use of drugs

has resulted partly from allegations by prisoners, which in one case led to a major riot, and partly from the work of the organisations which were for a time involved in the Medical Committee Against the Abuse of Prisoners by Drugging (Radical Alternatives to Prison, P.R.O.P., M.I.N.D., National Council for Civil Liberties, Standing Conference on Drug Abuse and Release). However, concern about the issue is by no means confined to radical organisations and prisoners: at various times it has also been expressed by some members of Boards of Visitors, M.Ps., present and former members of the prison service and some prison medical officers.

The deaths which have led to public concern about various aspects of the prison medical service include those of George Wilkinson in Liverpool prison hospital in 1979; of Richard Campbell in Ashford remand centre hospital in 1980; of Matthew O'Hara in 1980, two months after a short time in Pentonville prison hospital; of Barry Prosser in Birmingham prison hospital in 1980; of David Graham in 1981 following a remand to Low Newton remand centre and a sentence in Deerbolt borstal; of Terence Smerdon in Wandsworth prison hospital in 1982; of Jim Heather-Hayes by suicide in Ashford remand centre in 1983; and of Richard Overton after transfer to a hospital from Hull prision in 1984. Details of these and other cases can be found in an adjournment debate on Richard Campbell, Hansard, House of Commons, 8th August 1980, "The Death of Richard 'Cartoon' Campbell", Battersea and Wandsworth Trades Council, 1980; an adjournment debate on Matthew O'Hara, Hansard, House of Commons, 6th March 1981; an adjournment debate on Barry Prosser, Hansard, House of Commons, 1st July 1982; a World in Action programme, "Prisoners' Medicine", broadcast on 19th July 1982; "Deaths in Prisons", Prison Briefing No. 2, P.R.O.P., 1982; "Frightened for My Life" by Geoff Coggan and Martin Walker, Fontana 1982; and a letter concerning Richard Overton from Lord Elton to Robert Kilroy-Silk M.P. of 24th May 1984. The inquest verdict of "lack of care" in the case of Mr. Heather-Hayes led to the inclusion of a section on suicide precautions in the report of the Chief Inspector of Prisons on Ashford remand centre (1983), which was followed by a wider review of suicide precautions by the Inspectorate, whose findings were published in the report "Suicides in Prison" (1984).

The suggestion that prison doctors might be more likely to cover up abuses than N.H.S. doctors also received some credence from the report of the Inquiry by the Regional Director of Prisons for the South East Region into the disturbance in D Wing of Wormwood Scrubs in August 1979. This stated that information given to the Board of Visitors by both the Governor and the prison medical officer concerning injuries sustained by prison officers and prisoners was inaccurate; that, when a member of the Board went to the prison hospital and asked to see the reporting sick register she was told by the prison medical officer that he would have to seek authority before complying with her request, even though she pointed out her entitlement to see the register under the Prison Rules; and that, while she eventually saw the register, this required a great deal more pressure than she had even known necessary before.

More recently, the organisation Women in Prison has expressed concern about several cases involving women prisoners, and we understand that these have been brought to the Committee's attention.

In discussion of the above cases and issues, it has been suggested that the possibilities for an internal cover-up of abuses would be reduced if prison doctors were N.H.S. employees and, on the other side of the coin, that it would reduce the special vulnerability of prison doctors to unfounded suspicions and irresponsible allegations. On the latter point, the Home Office argues that changing the administrative arrangements for the provision of the service would not remove the readiness of critics to make allegations, since their suspicions are essentially of doctors who work in prison, dealing with people who by virtue of their imprisonement have lost many of the rights of the citizen, and that a change of employer would not remove such suspicions. We acknowledge that the latter argument has some force, and that the benefits of the proposed change should not be exaggerated; but we consider nevertheless that the incorporation of the prison medical service into the N.H.S. would go some way to increase public confidence in this regard.

(iv) Accountability and priorities

An important reason for resistance to proposals that the prison medical service should become part of the N.H.S., advanced by the Home Office in its evidence to the May Committee, is that the D.H.S.S. and health authorities "would have the awkward responsibility for determining priorities for a service for which another Minister is responsible". However, this would not be an entirely new concept within prisons: education services, chaplaincy services and the services of seconded probation officers are provided for prisoners by and in co-operation with agencies based outside the prison service.

The Home Office also disputed suggestions that amalgamation with the N.H.S. would improve the resources available for medical services in prisons and raise the standards of health care, commenting:

> "It is by no means obvious that the care of prisoners would rank higher in N.H.S. priorities, as determined by regional and area health authorities, against the conflicting demands of medical services to the public, than it does in Prison Department priorities, against conflicting non-medical demands related to the welfare and detention of prisoners".

Area health authorities, regional health authorities and the Department of Health and Social Security, "would all have more influence than the Home Office in determining the level of service provided, for which the Home Secretary would nonetheless be responsible".

The groundlessness of these fears can be illustrated by examining the position in Scotland and, more especially, Northern Ireland. In his book, "Prison Health Care" (1984), Dr. Richard Smith pointed out that the Scottish prison medical service, in contrast to that of England and Wales, is staffed almost entirely by part-time doctors. The service is run by a medical adviser to the prison service who reports not to the Controller of Scottish prisons but to the Chief Medical Officer in the Scottish Home and Health Department. Dr. Smith commented:

> "There is thus a symbolic separation between the medical service and the prison authorities, which is much easier to achieve for the Scots than for the English and Welsh because both prisons and the N.H.S. in Scotland are run by one department".

In contrast, the service in Northern Ireland is staffed mainly by full-time doctors. The prisons are run by the Northern Ireland Office "which, as well as supplying a link with the administration in Whitehall, operates like a Northern Ireland Home Office". The medical service, however, is run by a principal medical officer in the Department of Health, and he is answerable to the Chief Medical Officer. The links between the departments are complex, but the practical result is that the line of command of the medical service is clearly separated from that of the prison service itself. Dr. Smith suggested that this separation "has been useful within the politically highly charged climate of Northern Ireland" and that it was an important reason for the medical service's coping successfully with the rapidly increasing prison population which resulted from terrorist activities in the 1970s. He commented:

> "... interestingly the services in Scotland and Northern Ireland come in for much less criticism. The Scottish system shows that a prison medical service can be run with mostly part-time doctors, and both the Scottish and Northern Ireland services shows that prison health services can be run by health departments with no serious problems and with probable benefits".

We recommend that the prison medical service should be brought under the auspices of the National Health Service and that a statutory duty should be placed on regional health authorities to provide medical services to prisoners in their region.

SUMMARY OF RECOMMENDATIONS

The prison medical service should be brought under the auspices of the National Health Service and a statutory duty should be placed on regional health authorities to provide medical services to prisoners in their region.

Pending arrangements to bring the prison medical service under the auspices of th National Health Service, we recommend that:

(i) There should be increased opportunities for prison medical officers to atten courses of further training, to spend part of their time working in an outsid N.H.S. setting and for attachments between the prison medical service and th National Health Service.

(ii) There should be a review of the level of the "environment allowance" to asse how far it is realistic as a way of compensating medical officers for the natur of medical work in prison.

(iii) There should be greater opportunities for prison hospital officers to acquir training and obtain qualifications.

(iv) A much higher proportion of hospital officers should possess nursing qualifica tions, and attempts to recruit staff direct from the nursing profession should b continued and intensified.

(v) One or more external and specifically medical avenues of complaint should b made available to prisoners dissatisfied with their medical treatment.

(vi) Procedures should be adopted to ensure that prisoners' past medical records ar always obtained from their general practitioners, that steps are always taken t communicate information about their treatment in prison to doctors who may trea them on release, and that information about serious medical conditions suffered b remand prisoners is invariably communicated to sentencing courts.

(vii) A detailed assessment should be carried out of the number of prisoners wh require psychiatric care and of the nature of their mental disorders.

(viii) Efforts to ensure that prisoners with disorders falling within Mental Health Ac criteria are catered for in N.H.S. hospitals should be continued and redoubled.

(xi) A psychiatric assessment and treatment centre, staffed by a multi-cultural team o doctors, nurses and seconded probation officers, should be established within each Prison Department region.

Examination of Witnesses

MS VIVIEN STERN, Director, and MR PAUL CAVADINO, Senior Information Officer, National Association for the Care and Resettlement of Offenders, called in and examined.

Chairman

778. Good afternoon. You were sitting at the back, so you have heard the form of questions. Please introduce yourself and your colleague?

*(*Ms *Stern.)* I am Vivien Stern, the Director of NACRO and my colleague is Paul Cavadino, NACRO's senior information officer, who has made a special study of prison medical services.

779. Thank you very much for your extensive memorandum. As I said to the previous witnesses, we have all read it. We are not going to go through every point with you. We have chosen certain features which either are novel to yours or ones we have had doubts about and would like you to explain in more detail. So there are matters in your submission which we will not go into because you are talking to the converted. Could I start by taking up one of your recommendations which ran that one or more external and existing avenues of complaint should be open to prisoners. Could you tell us precisely what you have in mind in that remark and why it is important that it should be specifically medical?

*(*Ms *Stern.)* We would be glad to do that.

*(*Mr *Cavadino.)* To start from the existing position, as Mr Winterton said in questioning a previous witness, there is a number of outlets which prisoners who are dissatisfied with their treatment have at the moment. This applies to dissatisfaction with any kind of treatment in prison, not just medical treatment. They include complaining to the governor, to a member of the board of visitors, writing to an MP, petitioning the Home Secretary, and so on. However, none of those avenues of complaint is specifically medical. That therefore differs from the situation, for example, about dissatisfaction

Chairman *Contd.*]

vith treatment in the NHS where someone an complain for example to the district or egional health authority, the family practi- ioner committee, to the Health Service Ombudsman, and so on, to a range of odies which are medical in nature. Now, if can illustrate the problems which are aused by the fact that none of the prison omplaints procedures are specifically med- cal in nature, this may underline what we re saying. Members of boards of visitors vho receive complaints from prisoners bout medical treatment, and that consti- utes a substantial proportion of the com- laints they receive, often find themselves in ery great difficulty about pursuing them ecause they are lay people; they do not ave expert medical knowledge. Very often hey feel very diffident about questioning or hallenging a doctor's professional medical udgment. The doctors themselves may also ften take a dim view of a lay person uestioning or challenging their medical xpertise. So quite often the members of the oard may do little more than simply ecord the complaint in the hope that omething might be done, but that is clearly ot a very satisfactory or thorough investi- ation or complaints procedure. That is vhy we think that some kind of medical omplaints procedure, some system vhereby a medical person would have a ook at the complaint, and if something eeded to be done, try to ensure something vas done to put matters right, is important.

780. Do you see a role here for the Mental Health Act Commission as a eparate but allied body?

*(*Mr *Cavadino.)* One of our recommenda- ions is that each region of the Prison Department ought to have a regional assess- nent and treatment centre of a psychiatric kind within the prison service to provide oth assessment and treatment for prisoners eeding mental care, needing psychiatric are for mental problems. In so far as the Mental Health Act Commission might be elevant, it might be relevant to those units. n regard though to the current Mental Health Act, unless the unit were designated, s for example regional secure units within he NHS would be, as coming within the emit of the Mental Health Act, then the Mental Health Act Commission at the noment would not have jurisdiction over it. Nevertheless, there is no reason why, if it vere felt to be a sensible proposal, future egislation should not put that right. Cer- ainly a body of that kind would seem a ery appropriate body to supervise psychia- tric care. In relation to complaints about physical treatment, which have no particu- lar relevance to psychiatric care, then some- thing more akin to the complaints proce- dures which operate now in the NHS would suffice.

Mr Yeo

781. You suggested in your paper that communication difficulty, cultural differ- ences and so on relating to people from ethnic minorities, may lead to psychiatric mis-diagnosis, inappropriate treatment, and so on. Do you have actual evidence this is happening in prisons?

*(*Ms *Stern.)* When you talk about actual evidence, and you are not a doctor yourself, of course it is difficult, but we do have actual evidence of quite a high level of concern among some of the groups who help people from the ethnic minorities who are in prison and who are concerned with what happens to people from the ethnic minorities in prison. Not being doctors ourselves, it is very difficult to judge whether they have got it right or not. What we do know for absolutely sure is that those groups are extremely concerned and anxious. I think we also know that there has been over the past few years the growth of something I think is called multi- cultural psychiatry, which has involved people from that profession considering how far there need to be changes in order to incorporate people from different cultures. I think that if one reads those sorts of documents from a lay person's point of view it seems clear that there is a genuine issue about multi-cultural psychiatry and that there are likely to be very real problems about misunderstandings and about what can go wrong when people from ethnic minorities are mentally ill and find them- selves not being able to relate to those who are trying to help them. I think it is a real, genuine problem.

Mr Winterton

782. There are quite a lot of people from the ethnic minorities themselves who are psychiatrists within the hospital service. Why should the problems arise? There is a very high number of Asian doctors in the hospital service, but sadly perhaps not quite enough of the Afro-Caribbean, but cer- tainly on the Asian side you might say the white prisoners or inmates might be getting a little concerned that they cannot relate to an Asian psychiatrist. Really, just how far can we go down this path? I thought we

[Mr Winterton *Contd.*]

lived in a fairly homogeneous society. I would have thought the same rule for all should be the order of the day.

(Ms Stern.) If I can just answer that, we are not talking about rules. Of course, there should be the same rules for all.

783. And treatment for that matter then?

(Ms Stern.) I really would not consider myself qualified.

(Mr Cavadino.) The sort of concern that arises among many black organisations is that they are concerned that some members of ethnic minorities may be mis-diagnosed as mentally ill owing to problems arising from language communication and cultural problems. They have pointed out that black doctors, and indeed black social workers, working within multi-professional teams, can help their white colleagues in order to help them to appreciate those factors and arrive at a more appropriate diagnosis, treatment and care. Within the prison system exactly the same ought to apply. What we are, therefore, proposing is that if the regional assessment and treatment centres which we are suggesting were established and if they were staffed by a multi-cultural team of doctors, nurses and seconded probation officers, who would presumably provide the social work input as they do elsewhere in the prison system, that would help to overcome those problems.

Mr Galley

784. Can we return to the recommendations which you referred to before about the psychiatric assessment and treatment centre in each region, which is coupled with a recommendation relating to those with disorders falling under the Mental Health Act criteria, that relates back to the comment you were making before about the Mental Health Act Commission. I am becoming a little bit confused as to which direction you want to go. Do you want to put the prison medical service more into contact with normal Health Service provision or do you want to separate it and provide separate facilities within the prison medical service?

(Mr Cavadino.) We want to bring the prison medical service under the auspices of the National Health Service. That means that doctors working in prison, whether they are working full time in prison or part-time, would be employees of the NHS rather than of the Prison Department. So far as those who are mentally ill within the definition under the Mental Health Act are concerned, we consider that they ought not to be in prison at all. They ought to be in NHS provision within the hospital system. However, many of those people go to prison initially on remand and are subsequently diagnosed as being mentally ill, so they spend a period of time in prison on remand. Those who it is known are mentally ill and the courts cannot always regrettably find a place for, we would like them always to be able to find a place but at the moment a number of these people end up in prison, at least for a period of time, before they can be transferred. There are many people who are not mentally ill within that definition but are mentally disturbed and who end up in prison but who could not be compulsorily detained in hospital because they do not fall within the strict Mental Health Act criteria. Therefore it seems that we are going to have for a long time a substantial number of people who need psychiatric care in prison but by no means all of them are mentally ill within the Mental Health Act definition. Our proposal, therefore, is that those who are mentally ill as far as possible should be taken out of prison and into hospital. That is acknowledging that while at the same time we should redouble our efforts to do that, we are likely to continue to have a considerable number of people in prison needing psychiatric care, we think while in there they should get decent psychiatric care. The facilities for psychiatric care in prison at the moment are grossly unsatisfactory in many cases. We are proposing that these regional units should be established to ensure that, while they are in there, they get proper care.

785. Would there not be a temptation if you have specialist psychiatric units within the prison system to put into those units people who are mentally ill and ought to be in hospital?

(Mr Cavadino.) I do not think there would be such a temptation to a significant degree on the part of the courts. If you look at the way things have been developing over the last decade, it is the courts who have been increasingly irked that they cannot get the DHSS system to take people under hospital orders. They cannot always find the places. They want to make orders.

Mr Winterton

786. Why is it that they cannot find a place in a psychiatric NHS hospital for somebody that the courts believe would

Mr Winterton *Contd.*]

benefit from hospital treatment, rather than a prison sentence?

(Mr *Cavadino.)* Historically there have been a number of reasons. They have included the reluctance of some consultants to accept people because they felt that their system was not capable of dealing with them. In some instances that is related to the level of security which they could provide within their psychiatric hospital. So that in turn has been to some extent linked with the lack of medium secure facilities of the kind that were recommended in the mid-seventies by the Butler Committee. There has been a number of reasons as well as those. There has been a whole series of reasons. The courts have often ended up sending someone to prison while accepting that they should not be going to prison but simply because they could not find a hospital place in the area which would enable them to make a hospital order. We think efforts to remedy that problem ought to be continued and intensified and redoubled but even if we got to the stage where every court which wanted to make a hospital order could make one immediately, we would still have the situation of a lot of people being in prison who do not fall within the Mental Health Act criteria and on whom a hospital order cannot therefore be made, but who need psychiatric care.

787. You were not overlooking the fact that these people who appear before the court have committed an offence; they have broken the law?

(Mr *Cavadino.)* Yes.

788. You will not get away from that, will you, because clearly people would expect those who have broken the law to be dealt with in some way, either punished and put in prison, if it is appropriate, or, I agree with you, preferably, if they are mentally ill, to be dealt with in a psychiatric National Health Service hospital, but they have to be dealt with in some way otherwise you are going to lose the confidence of the public, are you not?

(Mr *Cavadino.)* Of course, nothing we have said is contradictory to that in any way.

789. Clearly you are seeking to get a lot less people into prison. You are saying they should be dealt with in other ways. What we have got to be sure of, and the public needs to know, is that there is adequate alternative provision, which clearly at the moment there is not.

(Mr *Cavadino.)* Yes. What we would like to see is the recommendation of the Home Affairs Committee in 1981 in its report on the prison service implemented. That said that in effect a court which wished to make a hospital order on someone should be able to make a hospital order and the DHSS should have a statutory obligation placed upon it to find a place for that person. That was not the precise wording of the recommendation but that was the gist of it. So far as those who have committeed offences which might be regarded as a serious threat to the community are concerned, then secure treatment may well be desirable but that should be provided within the health system if the person is mentally ill rather than within prison. So far as some less serious offenders are concerned, then probation orders could well be appropriate, if they were combined with supervision in appropriate hostels, and other facilities of the kind which this committee has rightly said are not available to the extent that they should be.

Mr Galley

790. I am still worried that if you have these specialist psychiatric units within the prison system, if there is somebody on a hospital order, might it not be easy just to say, "We will send him to that psychiatric unit", without really considering what that person needs in terms of their individual care, and almost let the authority off the hook in determining the most appropriate form of care?

(Mr *Cavadino.)* It is for the court to decide whether a hospital order or prison sentence should be passed. If you are saying, in a situation where the person clearly is mentally ill within the Mental Health Act definition, the court would be inclined to pass a prison sentence rather than a hospital order more readily, knowing they fell within the Mental Health Act criteria, I can understand the argument and this poses a dilemma. In general I do not think that would be the case, In so far as it would be a temptation, it is a temptation that ought to be countered in other ways than by leaving people who need psychiatric care in the kind of gloomy corridors of cells in which they are currently dumped in prisons like Brixton, Liverpool and so on, with grossly unsatisfactory treatment and very little in the way of opportunity for association and therapy. It cannot be right simply because there may be some other

[Mr Galley *Contd.*]

dilemma in a system which involved providing decent care for them to leave things as they are.

791. Would you envisage, with specialist units, there may be some problems of consent to treatment?

*(*Mr *Cavadino.)* I cannot envisage any greater problems with that than there are at the moment. One would hope that in a unit which was staffed in the way that we proposed, which hopefully had a higher level of staffing of nurses to patients for example than is often the case in prison hospital wings, it would be possible to provide care in a way which reduced the problem that can arise when consent to treatment issues arise. The danger, of course, is that, because of lack of adequate staffing, there may be a resort to medication and drugs in order to maintain control. It is within that situation the question of consent to treatment is most likely to arise. If people were in the situation where they were, with adequate staffing and professional staffing, receiving proper care, it should be possible to reduce the numbers of cases in which that might arise. I would have thought, although these issues will still arise in some cases, they ought to arise less often than they do now.

792. So you would see no need to bring those units under the ambit of the Mental Health Act?

*(*Mr *Cavadino.)* No, I did not say that. It depends what you mean by the Mental Health Act. If you mean under the scrutiny of the Mental Health Act Commission, there may be a case for doing that. What we are talking about are facilities that should be provided within the prison system, as distinct from within psychiatric hospitals.

Mr Kennedy

793. In common with others, you want the prison medical service under the auspices of the NHS and incorporated within the NHS. You suggest that fears that the PMS might lose out in resource terms, were that to happen, were groundless. May I inquire what the basis of your optimism is?

*(*Ms *Stern.)* Yes. If I say our optimism is based on what goes on at the moment, I do not want to suggest that is ideal. I think the model we have in mind is the model that obtains with the delivery of education services to prisons which, as you know, are delivered by local education authorities and are purchased by the Home Office. I think it has always been our view that it would be quite wrong for this to be a competition o resources within the NHS because clearl those fears that have been expressed tha prisons would lose out are right. We ar really talking about buying in a service an buying in employees, but not buying them if you see what I mean, just as educatio officers in prisons do not work for the Hom Office. They work for their local educatio authority and that local education authorit is reimbursed for that service. I think that i the model we have in mind.

794. You certainly would not want spe cific earmarking?

*(*Mr *Cavadino.)* The point is that i relation to the prison education services, i is the Home Office which decides what th budget will be and how much education it i prepared to buy for prisoners in a year. Th delivery of the service is then done by employees of a local education authority. I is perfectly true if you handed budgetary control over to regional health authorities there might be a danger that it would end up very low on the list of priorities in relation to other calls on the budget. We are not suggesting that. The Home Office would decide on the budget for the prison medical service but it would then be brought in from the regional health authorities who would have a duty to provide the health service.

Chairman

795. It would be a contractor relationship?

*(*Mr *Cavadino.)* Yes, it would, and those who were operating within prisons in a medical capacity, even if they were full-time, would be employees of the regional health authority but it would not be that authority that was laying down the budget because then you would have the danger.

Mr Winterton

796. Laying down the budget or paying?

*(*Mr *Cavadino.)* Yes.

Mr Kennedy

797. Finally, to clarify that, if we leave the contentions to one side, if we just accept this fact, that, for example, the funding of regional secure units can be used as an argument for a lower priority being afforded by the health authorities' sector, you would not see that arising because of the distinction in the relationship?

*(*Ms *Stern.)* It would be quite a different relationship, as it is in education, because

Mr Kennedy *Contd.*]

Clearly there are many priorities in education. If prisons were to be on the list I suspect it would not be very high up. As it is, it is not an issue because they get paid for what they deliver.

Mr Winterton

798. How much research have you done into this? I know Mr Kennedy is pursuing this, and rightly. To me it is a very interesting proposal to put forward. Have you actually done much research into this? Have you sought to produce a model to see how it might work?

(Ms Stern.) We have not sought to produce a model and I do not think we would claim that we come with a fully worked out blueprint because I think that would be beyond our competence. Looking around at the other models that there are for the delivery of services to prisoners, we do know quite a lot about the educational one and we have talked to your colleagues about it on occasions. I think we feel that of the models that there are, it deals with a lot of the difficulties that you would expect to be with outside agencies having it as a low priority, with staff having divided loyalties, and with whether the service is of a high quality, with someone being responsible for the quality of the service, and having a clear responsibility for that.

Mr Kennedy

799. You would be against incorporation if it meant that prison heath services came in the batting order or priorities for a health authority?

(Ms Stern.) We would definitely fear that that would lead to a reduction in the quality of what is offered, as understandably that would not be a high priority.

Mr Winterton

800. My question follows on Charles Kennedy's very well indeed because you reject, if I have read your evidence correctly, the Home Office's argument that there will always need to be a full-time HMS in order to advise management on health and hygiene. You do so on the ground that these duties would be more appropriately passed to local environmental health officers. Can you tell me if you find the argument, therefore, if that is your belief, that full-time MOs will be needed to write psychiatric reports any more convincing?

(Mr Cavadino.) I think our evidence does not suggest that you would not need some full-time medical staff. We are saying that medical staff in prisons, whether full or part time, should be employees of the NHS rather than of the Home Office. If you take the duties which prison medical officers carry out, which are not providing care to individual patients, they include substantial amounts of report writing and they include responsibility for environmental health matters within prison. Now, some of these duties could be carried out, and would be more effectively carried out, we believe, by other bodies. Others though have to be carried out by doctors working in some capacity in or to the prison system. The environmental health inspection duties we believe would be carried out by local authority environmental health officers. The position at the moment is, as you no doubt know, that prison medical officers have this duty, for example, of inspecting prison kitchens. There is no system comparable to the one that there is, for example, in hospital kitchens, whereby local environmental health officers are invited in to advise even though that system has been under criticism recently and is to be changed, because Crown immunity means that where regulations are made, but not carried out, the Crown cannot be prosecuted. Nevertheless, there has at least been a system of inviting in local environmental health officers to hospital kitchens to inspect and advise.

801. Are you saying that that does not exist within the prison or you do not believe environmental health officers are invited in at all?

(Mr Cavadino.) They are sometimes invited in. If there is a salmonella outbreak or something goes wrong of a particular kind, the medical officer will, in those instances, certainly invite in the environmental health officer. There is no system of regular inspections, or at least there has not been traditionally up to now. Prison medical officers themselves have criticised the current system as being inadequate and have said they are not trained in environmental health and the Prison Medical Association, for example, has argued that environmental health officers should come in and carry out these inspectoral duties. We would support that and we would want Crown immunity to be abolished for prisons as well as for hospitals. The report writing side of a prison medical officers' duties cannot, I think, simply be handed out to some external body in the same way. That though, I think, should be carried out by prison medical

[Mr Winterton *Contd.*]

officers who are employees of the NHS but who, nevertheless, are working as prison medical officers either full time or part time.

802. Could I just get on the record that in all the discussions which you heard from the previous witnesses and from the questions we have put to you, and the evidence you have given to us, I presume you are not, as it were, condemning out of hand or seeking to denigrate the excellent work which is done by the hospital officers within the prison medical service?

*(*Mr *Cavadino.)* Certainly not; indeed, the hospital officers have been among those in the forefront of calls for better training. This comes out very strongly, for example, if you look at reports such as the one the Chief Inspector of Prisons did on Birmingham Prison after concern aroused by the Barry Prosser case in which he paid tribute to a lot of the care that hospital officers provided for people in their charge, but also stressed the views which were expressed to him very strongly by hospital officers that they felt the need for greater training and for the opportunity to acquire greater qualifications and their representative organisations, such as the Prison Officers Association, have argued that very strongly indeed.

Mr Galley

803. You refer in your paper to 'internal cover-up of abuses', and quote some evidence, some of which seems to be of an anecdotal nature. Do we have much hard evidence that there is extensive covering up of abuses within the Prison Medical Service?

*(*Mr *Cavadino.)* The section of our submission which deals with the possibility of covering up abuses has referred to a number of concerns which have been expressed in recent years. Some of them arise out of individual cases and some of them arise out of allegations which have continued for a long time about the alleged excessive use of medication in prisons. Now, there was also a particular situation at Wormwood Scrubs in 1979 which is documented in our submission and which gave rise to concern. We have not suggested that we ourselves have extensive documented evidence of specific abuses being covered up, but we would refer the Committee to the reports which we have listed there, which other organisations have compiled, which have given rise to that kind of concern. What we are saying is that if there is an abuse which occurs in prison then it has been suggested on the one hand that doctors who are employees of th Home Office, rather than of the NH might be readier to take part in a cover-u of any such abuse. Secondly, it has bee suggested that if there are unfounded all gations, doctors would be less vulnerable unfounded allegations if they could seem be responsible to the NHS rather than the Home Office. We consider that bo those arguments have some force, and seems to me that they would have son force even if there had been only one abu of any kind in the prison medical servi throughout the establishments in Englar and Wales in the last twenty years.

Mr Winterton

804. From the investigations we hav made, especially from inmates, there ha been a dearth of medication rather than a excess of medication in recent times. Is tha not also your view?

*(*Mr *Cavadino.)* It is not my view. It is m view that prisoners would express that viev

805. Can you tell me why prisoner would, in fact, express that view, unless tha view was the accurate one and the true one

*(*Mr *Cavadino.)* For the same reason tha people going to GPs in the National Healt Service will often complain if they are no given some fairly strong medication fo their complaint and the GPs, and the sam applies to prison doctors, are under con stant pressure to prescribe drugs. The themselves sometimes may feel a tempta tion to take an easy way out by prescribin drugs in order to get someone out of th surgery.

806. Would you consider that was mor accurate if we had that information fro doctors and pharmacists within the priso medical service, that there had been reduction in the prescribing of medication

*(*Mr *Cavadino.)* There has been a reduc tion in the prescribing of medicine in recen years. It is difficult to tell precisely statis tically how much that is because the natur of the statistics covers up a number c things. For example, they have developed drugs which can be administered in on dose, with a certain strength, lasting certain number of days, which a few year ago might have been several doses, each o which were smaller in amount. It is difficul to tell from the figures precisely how muc it has gone down. It does seem to b generally agreed it has gone down. I thin this partly arises from concern about th level of medication at some prisons an

gures vary a great deal from one prison to nother. It may also arise from concern in ie medical profession and outside the iedical profession generally, not just ithin prisons, about the level of medica- on which was being dispensed to some atients with the risk of increasing depen- ency. The point therefore which you raised bout many prisoners complaining that ney are not getting drugs is a valid one. In me of those instances it could be that the mplaint has some justification. Similarly, hen people complain about not getting rugs from their GP, it could be in some istances the complaint has some justifica- on. There is also, of course, the real ilemma that a doctor will find himself in of eing pestered for drugs when it may be his iedical judgment tells him that dispensing rugs which may be the easy way out is not ecessarily the right thing for the patient. low, in discussing these issues, many of hich are not peculiar to prison medicine, iere is an additional dimension in relation prisons which is that there will inevitably e suspicions arising that because prisons re closed institutions and closed to a onsiderable degree to public scrutiny, be- ause they are institutions which exert a onsiderable degree of discipline and con- ol, that medicine might be misused to ose ends. If prison medicine were part of ie NHS, if the doctors who were prescrib- ig in prison were doctors who were em- loyed by a health authority outside rather an by the Home Office, which is respon- ble for the disciplinary aspects of prisons, seems to me that those suspicions would ievitably be lessened.

807. You are casting somewhat unfortu- ate aspersions upon the medical profession saying that people in the Health Service re likely to be rather better because they re more accountable than those within the rison medical service who are also profes- onal but, perhaps you may say, less ccountable. Without evidence, it is rather n unfair allegation.

*(*Ms *Stern.)* I do not think that is what as said. If I could perhaps elaborate, I ink what was said was that when people re working for a different authority from ie one that is exercising the disciplinary ontrol, they are in a much better position speak out to defend themselves and to be garded by the outisde world as indepen- ent. They could be exactly the same people day, working for the Home Office, and morrow working for the NHS. This has ally very little to do with the quality of the individual. It has to do with how they are seen by the outside world and how they are able to participate in debate. Those are the issues that I think were raised. They could very well be the same individuals.

Mr Winterton: Thank you very much for clarifying it.

Mr Yeo

808. Moving on to another subject, the Committee learnt during some of the visits, about work done by voluntary organisations in counselling, people like Alcoholics Anonymous. Does NACRO have any projects of that sort?

*(*Ms *Stern.)* We do not have any projects that are specifically concerned with health. We are concerned with other aspects of prisoners' welfare. We go into prisons a great deal. We are concerned with fixing people up with accommodation, talking on pre-release courses, and that sort of thing.

809. In other words, nothing that impinges on medical issues?

*(*Ms *Stern.)* It impinges in that people come out of prison to us and there are a lot of administrative matters connected with prison records not reaching GPs, prisoners not coming out with a letter about what treatment they are getting. Then the person has to go to the hospital or find a doctor and no-one is clear on the problem. There is a lot of that sort of problem which I think is set out in the memorandum which is technical and quite important to each individual who comes out of prison and needs medication and then the doctor which we arrange for him or her does not know what to do.

810. Actually, it is on coming out that one of the concerns arises. A lot of good work that may be done by these organisations during the time in prison is lost because there is no real follow-up afterwards. Is there anything you can suggest to be done to improve that?

*(*Mr *Cavadino.)* Yes, there is indeed. There are some good examples of after-care projects which have been developing in this field. One, for example, is the Parole Release Scheme which has worked closely with Wormwood Scrubs Prison to try to provide aftercare for prisoners with drug problems released on parole. The Wormwood Scrubs Annexe is one of the few places within the prison system which provides decent therapy for people with drugs problems. This Committee has rightly proposed in another report that there should be more

[Chairman *Contd.*]

such units. The Parole Release Scheme has worked to try to provide continuing care for people with drug problems from Wormwood Scrubs through to a supportive hostel situated in the community which can provide appropriate care for a drug dependent person on parole under that scheme. There are good examples but they are very few and far between in relation to the extent the need throughout the country.

Chairman: May I thank you both ve much for your evidence. It has been e tremely interesting. We could go on a gre deal longer but we have another set witnesses waiting.

Memorandum submitted by the National Council for Civil Liberties

The National Council for Civil Liberties was founded in 1934 to maintain and exte civil and political liberties. It has been advising prisoners almost since its inception and the 1950s was campaigning to reform the mental health laws and has had a continui interest in the treatment of mentally disordered offenders. Besides considering penal poli and carrying out research into issues relating to the residual rights of prisoners, NCCL leg officers act as solicitors on behalf of prisoners. In this latter role, we are increasing involved in taking cases for judicial review of decisions of the Secretary of State Governors of prisons. NCCL legal volunteers, trained barristers and solicitors who meet NCCL each week, answer approximately 500 letters from prisoners each week. Append 2* is a list of complaints extrapolated from those letters relating to the prison medic service. Over the years we have received few written complaints from women in prison b have recently been contacted by female ex-prisoners and through them have becon concerned about the level of medical treatment for women in prison. It is because of th concern that we asked the Bishop of Stepney and Professor Anthony Clare to evaluate tl psychiatric facilities of C1 unit. Their report is Appendix 3*. We are starting to recei disturbing allegations about the treatment provided for pregnant women and for babies the prisons' mother and baby units. This does not mean that the treatment has become a worse necessarily, only that women have only recently started to contact NCCL about the matters. As some of the cases in which we are involved are presently sub judice we a unable to include them in this submission. However, we would appreciate an opportuni to give all our evidence to the Committee in October when we hope these legal matters w have been resolved.

Protecting the Health of Prisoners

1. Doctors in the Prison Medical Service have responsibility, not only for providir medical treatment for individuals prisoners, but also for advising the prison authorities c the measures necessary to protect the health of prisoners in general.

2. Much of the responsibility for the protection of health is shared with others, but th doctor has the special duty to maintain regular surveillance over conditions in the pris likely to affect health as well as over the incidence of particular forms of sickness.

3. Much of this is routine, such as the control of infections. The doctor keeps an eye to on the diet offered to prisoners, and on general environmental conditions, such a ventilation or temperature control.

4. Special problems arise from time to time. Here is a recent example. After a few days c bright sunshine, several prisoners presented with skin rashes. An alert medical officer note that all those affected were receiving a psychotropic drug (Largactil) known to produ photosensitivity as an adverse effect in a small proportion of cases. Prisoners tend to be le exposed to sunlight than is usual and therefore more liable to the adverse effect. H reviewed the policy for prescribing the drug, and took steps to ensure that those receiving were advised to reduce the exposure by keeping their skin covered. A similar cluster c

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* Not printed.

ses of rashes might have arisen through the use of an irritating chemical in a prison rkshop. These are examples of relatively easy medical problems that may arise in any ge community. More difficult are the clusters of mental symptoms.

5. *The promotion of health.* A medical officer has a general duty to promote health rough education on diet, weight control, regular exercise, reducing smoking, etc. There e obvious difficulties in pursuing health education with prisoners, but he can give the thorities advice that leads to improving the diet, facilities for exercise, and other nditions.

6. *Mental health.* The measures necessary to protect and promote physical health are ostly well recognised. Less so, and more controversial, are the measures necessary to otect mental health. But the protection of mental health is of great importance, especially since it is known that a proportion of prisoners suffer from actual mental illness, hough there may be differences of opinion about what proportion. A substantial oportion suffer from a personality disorder. The mental stability of others is precarious. rtainly, the mental health of prisoners as a group tends to be unduly vulnerable.

7. There are regimes and procedures in prisons that might be expected in some rcumstances to impose stress on those subjected to them, because for instance they reduce assuring social contacts or produce a degree of sensory deprivation. Solitary confinement, ule 43, frequent moves in accordance with Circular 10/74, and interrogation are amples.

8. There is a striking dearth of evidence on the effects of such regimes and procedures on ental health. The research has not been done which would allow these effects to be aluated. That there has been so little research must be regarded as a failure, for which the edical services are at least partly responsible.

9. An extreme example, for which the prison medical services were not to blame, was the troduction of the procedures of interrogation in depth by the security forces in Northern eland[1]. These procedures were brought into use for security reasons, but without regard to e possible damage they might do to the mental or physical health of those subjected to em. Had medical experts been consulted, they would have warned against them, as Lord ardiner's retrospective minority report[2] shows.

10. That possibly harmful procedures may be introduced without medical advice raises estions about the responsibility of doctors for the monitoring of what is done in prisons at could have effects on health. The British Medical Association in *The Handbook of edical Ethics*[3] seems to take the view that the doctor waits to be asked for advice on a rticular prisoner "subjected to close confinement or reduction of diet", for instance. If he asked and then decides that "the procedure is excessive and dangerous to the prisoner's alth", he "should make a written report and then refuse to be further associated with the ocedure".

11. This is too passive a role for the doctor. It should be his duty to monitor what ppens in every case in which he thinks the health of the prisoner might be put at risk. nd he has the further duty to record any symptoms which might follow, so that the data is ailable on which the medical effects of the procedure can be evaluated. It is agreed that, he advises against the procedure on medical grounds, he should do so in writing, but he ould also give the reasons why there might be a risk to health, and what ill-effects he ticipates.

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[1] "Compton Report" *Report of the enquiry into allegations against the security forces of physical utality in Northern Ireland arising out of events on the 9th August 1971.* London: HMSO, 1971, Cmnd 23.

[2] Minority report by Lord Gardiner in "Parker Committee" *Report of the Committee of Privy unsellors appointed to consider authorised procedures for the interrogation of prisoners suspected of rorism.* London: HMSO, 1972, Cmnd 4901.

[3] Published by the British Medical Association, 1980, para 7.18.

12. The participation of a doctor in any potentially harmful procedure raises awkwa ethical questions, which have been much discussed[4]. Either he may refuse to have anyth to do with it. Or he may continue to give medical advice while making it clear that he is r party to the procedure, and that his attendance does not imply that he approves of it. In c opinion, the latter is the better approach.

13. Much of the psychiatric research in prisons has been concerned with questions abo how many prisoners should be regarded as mentally disordered, or how many would more appropriately transferred to a hospital. Systematic studies do not appear to have be made by psychiatrists or psychologists on the effects of prison conditions, regimes a procedures on health. This contrasts with the many studies made in industry about t incidence of various forms of ill-health and the part played in them by particular hazards by factory conditions in general. Especially since the Health and Safety at Work Act the has been regular monitoring in workplaces. Increasingly sophisticated records of a untoward effect on health are being kept. What is done in prisons is still rudimentary comparison. Yet the health hazards of being a prisoner are known to be high, either terms of mortality or morbidity.

14. One of the reasons for the lack of systematic studies on the health problems special prisons may well lie in the relative isolation of prison doctors from their colleagues in oth branches of medicine. Doctors working in almost every branch of the NHS regularly fa the friendly criticism of colleagues, and are regularly reminded, especially nowadays, of t shortcomings in the evidence on which they base their claims of doing a useful job. Th are under pressure to undertake systematic studies in their speciality, as is entire appropriate in a profession, in order to discover the incidence or prevalence of the illnes they treat and to evaluate the efficacy, effectiveness or economy of their treatments. Th face too the sceptical questions of not only their patients but also their students. Pris doctors tend to lack the stimulus that comes from membership of a network of professio colleagues with a wide range of skills and viewpoints.

The Management Role of Medical Officers

Prison medical officers are required by the Prison Rules and Standing Orders to play considerable part in the authorization of certain key disciplinary and control measures. T three major roles are as follows:—

(i) No disciplinary adjudication may proceed unless a prisoner has been certified as " for adjudication" after being examined by the prison medical Officer. (Standi Order 3D 14). Nor can any punishment be imposed for which the prisoner has n been certified fit: this is of particular significance when the punishment of cellul confinement is to be imposed. (See Rule 53)

(ii) A prisoner "removed from association" and segregated under Rule 43 must have h segregation terminated if the "medical officer so advises on medical grounds". Th the medical officer has an effective veto on the continuation of Rule 43 Seclusio

(iii) The continued "restraint" of a prisoner under Rule 46, employing some physic mechanism of restraint, must be discontinued or modified the moment that medical officer "recommends". (This, of course, applies to the use of body-belts

Prison medical officers also play an important managerial role in "fitting" prisoners f certain kinds of work, and excusing them from work in accordance with the provisions Rule 28 (2).

Concern at Performance of Management Role

The NCCL has received complaints as to the performance by medical officers of the

[4] eg paras 7.18–21 in *The Handbook of Medical Ethics;* Prisoners *by Scott PD, Bowden P.* Dictionary of Medical Ethics, *2nd edn. eds. Duncan AS, Dunstan GR, Welbourn RB. London: Dart Longman & Todd, 1981, pp. 339–43; Davis DR.* Interrogation in depth. *In*: Gradwohls Legal Medicir *3rd edn. ed. Camps FE. Bristol: John Wright, 1976.*

e in safeguarding prisoners from the abuse or inappropriate use of disciplinary and ntrol measures. In particular:—

Certificates for "Fitness for Adjudication"

There is ample evidence that prison medical officers frequently perform their task of ting for adjudication in a perfunctory and inadequate manner. For example:—

(A) Some days before the suicide of 18-year old Jim Heather Hayes at Ashford Remand Centre, he was declared fit for adjudication, and was subsequently convicted and sentenced to cellular confinement. The doctor who "fitted" him for adjudication gave the following evidence to the coroner's court on his method of fitting for adjudication:—
"I go into a cell with one of the officers and I say "Good morning, are you alright?" and I wait for an answer. Most say nothing: Heather-Hayes said nothing. I left the cell." The coroner's jury which returned a verdict of "lack of care" clearly took the view that there had been signs for some time prior to this young man's death of mental disturbance, and suicide tendencies, that had not been detected through negligence on the part of the prison authorities.

(B) In another more recent case the perfunctory method of ascertaining "fitness" for adjudication described by the doctor in the Jim Heather-Hayes case was witnessed by a prisoner's representative whilst the prisoner awaited adjudication with his lawyer at Long Larkin prison. The doctor put his head round the door and said "any problems?", and on receiving no positive response left. Later this was treated by the Board of Visitors as a sufficient "examination" to make the telephonic communication of the prisoner's fitness for adjudication valid. That was against a background when an independent consultant called in by the prison to examine the prisoner had described him as "psychotic" and "paranoid"; and when the "false and malicious allegations" on which the prisoner was charged had a remarkably paranoid flavour to them. Nonetheless he was convicted; although the Board of Visitors subsequently announced defeat when judicial review proceedings were commenced. What is most alarming about the case is that the prisoner had just come from another prison hospital, and there was ample evidence to call into question his mental normality. Yet the doctor "examining" him for "fitness" contended himself with the aforementioned perfunctory procedure.

These two examples are not isolated instances. But they are increasingly verified and ell-documented examples of what any prisoner will tell the inquirer about the manner in nich "fitness for adjudication and punishment" was habitually exercised.

) *Authorization of removal from Association*

Again there have been many complaints that doctors do not intervene to terminate Rule seclusion even in cases when prolonged and psychologically damaging seclusion has early had serious effects on a prisoner. The absence of any medical veto is then put rward by the prison authority as proof that the continued seclusion was perfectly proper, d medically safe. Yet in a number of recent cases, independent psychiatrists have found at prisoners segregated to long periods without any medical "veto" have indeed suffered rious psychological damage as a result.

i) *Authorization of Physical Restraint*

The authorization of physical restraint by mechanical or other means (e.g. "body-belts") another area where the extent of safeguards provided by the medical officers is estionable. The evidence of a massively disproportionate use of body-belts at andsworth prison in the last year is not matched by any evidence as to the adequacy of edical safeguards operated then. Indeed in one recent Wandsworth Board of Visitors' judication it emerged that the prison medical officer who examined a prisoner restricted a body-belt was not even aware that the prisoner was in a body-belt! One wonders how e court can effectively decide whether or not to exercise his power of veto in such rcumstances.

RECOMMENDATIONS AND DISCUSSION

The NCCL recognizes that the prison rules and standing orders impose on medi officers certain functions in relation to disciplinary hearings, segregation and physi restraint in order to safeguard the physical and mental welfare of prisoners. But there ample evidence that these safeguards are not effective. If medical officers or their success are to exercise such functions then they must do so fairly and effectively. But there a dangers to the construction of the present system in that it inevitably requires medi officers to perform a managerial and disciplinary role and it means that when they decli to veto a particular punishment, or to interfere with continued segregation or restraint, t measures are given a bogus medical "imprimatur" which forces to prevent further legal political questioning of the procedures employed.

In the light of the forgoing, the NCCL would suggest the following charges:

(i) *The Prison Medical Service should be integrated with the NHS*

Under the new system, no one official doctor would have the power to veto (or refusing to veto, to implicitly authorize) any particular punishment, or any act segregation or restraint. However the *advice* of a doctor on questions of fitness adjudication and punishment, continued segregation, and physical restraint should mandatory in the same circumstances as the present rules and standing orders provide f That advice would remain advice. The responsibility for the first decision would remain the relevant prison authority/tribunals. This would mean that the burden of justificati both morally, politically and legally would rest on the prison authorities and the releva tribunals. (BOV or new style tribunal) It would also mean that the medical professi would not be required to compromise its independence by participating in the actu authorization of punishments, segregation or restraint. The medical profession would called on for advice. In appropriate and difficult cases second opinions could and should sought.

(ii) *Certification of Doctors*

With the abolition of the prison medical officer, there might be some need to "certif certain doctors as fit to carry out the task of giving the necessary "advice" envisaged abov (c.f. The Certification of doctors empowered to make "recommendations" for a Secti under the Mental Health Act). This formula ensures the availability in any one area doctors prepared to and qualified to offer their expert advice on the specifically *medic* issues raised by fitness for adjudication and punishment; segregation; But it remains clearly recognize that these decisions are ultimately issues of a moral and humanitari nature which the prison authorities should take themselves and for which they would in cases be accountable in the first analysis.

Examination of Witnesses

MR TIM OWEN, Barrister, MS MARIE STAUNTON, Legal Officer, PROFESSOR DEREK RUSSE DAVIES, Emeritus Professor of Mental Health, University of Bristol, National Council f Civil Liberties, called in and examined.

Chairman

811. Good evening. Could you introduce your team to us, please?

*(*Ms *Staunton.)* Certainly; we are a team who are really involved in advising and acting for prisoners. I am Legal Officer and Solicitor for the National Council for Civil Liberties. We answer about 2,000 letters a year from prisoners. We act for prisoners in both judicial review cases and go to prisons and act in adjudications in front of boards of visitors. On my right is Mr Owen, barrister, who also acts for prisoners in bot judicial reviews and boards of visitor hearings. On my left is Professor Russe Davies who is Emeritus Professor of Menta Health at Bristol University. He is ofte called on by solicitors to give reports c prisoners on the effect of conditions c them and on their mental health.

Chairman: You were sitting at the back, s you have some idea of how we proceed. W

Chairman *Contd.*]

ould like to ask you some questions based your written submission.

Mr Galley

812. You say in the introductory remarks your submission: "We are starting to ceive disturbing allegations about the eatment provided for pregnant women id for babies in the prisons' mother and by units". You do not elaborate on that your report. Are you able to tell us more out that?

*(*Ms *Staunton.)* Yes. The position at the ne was that at least one of the matters was b judice. The difficulty that one has I ink as a lawyer is that when somebody mes to us and is actually making allega- ons about the type of treatment they are iving or themselves and their baby are iving in the mother and baby unit, there is ry little we can do about it. It is generally itside our competence. The cases we make nerally are on what level a certain de- sion is taken within the Home Office. One the things that has concerned us, and one the things that we would be very keen to e research on, but do not know of research i, is the way in which mothers and babies e treated in prison. The reports we have t, incidentally, in other cases relating to others and babies in prison, have raised I ink the worrying question, and no more an a question, about whether people who id up in mother and baby units, who emselves, for example may have been used as children,—and this does not ply to any of my clients—are being eated in a way which is in accord with odern practice. If, in fact, what is happen- g is their negative impulses towards their ildren are just being reinforced. To what tent does one need greater expertise into ose units? We put that in because we have more than a question on it. When these estions arose we looked and tried to find hat research had been done on mothers id babies in prison. Certainly there is me research on the most recent mother id baby units which were set up. The area s been looked at but we would say no ore than that. Incidentally, in doing cases the different point of mothers and babies prison, very serious questions have been ised.

813. We have found in our admittedly nited evidence, a high quality of nursing re and advice available in mother and by units.

*(*Ms *Staunton.)* The cases we have had, and that is why we would like to see research on it, looking at case notes in detail on those cases, have raised queries as to two things; one is the decision to separate a mother and baby when they are once in prison; what criteria you use; and to what extent the medical reasons are taken into account. Secondly, there is the quality of care which the patient as a consumer feels that she gets, which is a matter on which we have not seen any research.

814. You say this does not necessarily mean that treatment has become worse, only that women have only recently started to contact you about these matters. Why would that be the case?

*(*Ms *Staunton.)* Simply because we have recently had social workers referring cases to us, women whom they have known outside prison, who have gone into prison and been with mothers and babies and for some reason social workers have suddenly started referring to us, the impetus having come from the women themselves. We receive very few letters from women in prison.

Chairman

815. Professor Russell Davies, could I ask you a question specifically? You say in your paper that the mental health of prisoners as a group tends to be "unduly vulnerable". I wonder if you could expand on that and tell us just what you mean by "unduly vulnerable"?

*(*Professor *Russell Davies.)* I think as a group they are unduly anxious; they have a poor sense of identity and a poor sense of themselves; a relatively high proportion have had previous psychiatric illnesses. There is a number of things of that kind, which means that they are more likely to respond unfavourably to stress than would a general sample of the population.

816. How far have we got reliable statistics on this very point, that there is a higher percentage than the average in the population of bad psychiatric record?

*(*Professor *Russell Davies.)* I think the difficulties are that these statistics are very poor, such as they are, and they are in fact, I think you are quite right, lacking.

Mr Yeo

817. You have actually referred to lack of evidence on the impact of the prison

[Mr Yeo *Contd.*]

regime. What kind of research do you think should be undertaken in that case?

*(*Professor *Russell Davies.)* I think, to start with, really one has to feel one's way. These are quite difficult things to do research on but one wants to start off as one starts with any kind of research problem, simply to plot the occurrence, to do the epidemiology, if I may use the word, to show how cases are spread in relationship to the various places and the various things that are happening. We know that psychotic break-downs in prison are relatively common, not very common, but they do occur. We do not know very much about where or when.

Mr Winterton

818. Professor, why, as the Emeritus Professor of Mental Health at the University of Bristol, have you not yourself taken any initiatives to have this research carried out, or have you taken any initiative to have this carried out, which clearly would be valuable to this Committee, and perhaps to the work of your own organisation, in assessing the strength of the views that you have expressed in your document?

*(*Professor *Russell Davies.)* I have at various stages made suggestions to the Home Office about this, but have had a completely blank response.

819. What about your own university?

*(*Professor *Russell Davies.)* In my own university we did develop some work at Horfield but that, in fact, fell down when the medical officer changed and we lost the particular person who was doing it. There are difficulties about funding this kind of research which we have not been able to solve.

*(*Mr *Owen.)* On the lack of research, from the legal point of view, we have had difficulties in representing prisoners at boards of visitors' adjudications, after they have been found guilty, and on the issue of what punishment is appropriate. One of the things Professor Russell Davies has said is that there is complete lack of research on the effects of certain prison regimes on mental health, as an example. When a prisoner has been convicted of a disciplinary offence before a board of visitors, the issue is often raised as to whether or not they are fit for cellular confinement and, of course, a board can sentence a prisoner for 56 days for any one offence. What one finds are two problems. There is a lack of research on the effects of this type of regime generally, so one is not in a position to say to the board of visitors, "Look, this pers has been in cellular confinement in the p for X number of days". We do not kn what the effect of continued segregati may be. There is also the other problem th one cannot get independent medical asse ments to assess how an individual prison may be affected by continued cellu confinement.

820. You do not give any credence to t professional integrity of the prison medic officer?

*(*Mr *Owen.)* I do not think that is true all. What one is saying—

821. What role does he have to pla Clearly while he will not be a party to t decision of the governor and the discip nary body in the case of an offence with prison, he is going to express a view abo the health of that prisoner as far as knows it. Certainly many of those we ha met are very committed and highly profe sional people.

*(*Mr *Owen.)* May I come back on that? all my experience of representing prisone at boards of visitors' adjudications, I ha yet to have a doctor called to give li evidence as to this certificate of fitness f adjudication. In all my experience, pris doctors come in on the morning of th adjudication, while I may be having conference with my client in the prison, ar literally put their head round the door ar say, "Are you all right?" The prisoner loo up and says, "Yes", and that will be it. Th next we know is that there is a certifica before the board saying that this person fit for adjudication; that is that.

822. That is precisely the point I a making. I would have assumed, and presume you would, that if the doctor w in any way unhappy about the medical physical condition of that prisoner, h would have made his view known to th authorities; yes or no?

*(*Mr *Owen.)* Well, what I say is that th doctor is not able, perhaps because of lac of research, to know what the effect of th regime is likely to be, and that is where th lack of research comes in. As far as I a aware, there is no detailed medical researc which any doctor, I am not saying th prison doctor in particular, as they are le well able to do it, could really use to advis a board of visitors, this committee, or th courts on adequacy or danger to health c continued segregation.

[Mr Winterton *Contd.*]

823. There may not be research, but that es not mean the prison medical doctor ay not be aware of the situation and have nsiderable experience and reach a judg- ent.

*(*Mr *Owen.)* Yes, that may well be true. I n not saying they deliberately give advice a board which they know not to be right. ne is aware, and this is where it is linked the problem of a medical officer who is officer in the prison in the same way as a ison officer is, he is being constrained by e requirements of discipline and control d put under some pressure to comply th what the regime considers to be the st dispersal of individual prisoners who, I cept, may be very difficult persons with nich to deal.

Chairman

824. You are not questioning the integ- y of the individual. You are rather saying is an individual judgment and he has not t the secure ground of solid research data a base by which he can refer the dividual case for judgment?

*(*Mr *Owen.)* Yes.

*(*Professor *Russell Davies.)* If I may put it a slightly different way, there are people no treat measles extremely well, but there e also lots of people who look to see where easles crops up and whether measles has come unduly common and so on. These ke two different kinds of doctor. I do not ink anybody is saying that the person who treating those measles, whether in prison elsewhere, is doing it badly. What we are ying is we ought to be doing a lot more out the distribution of, particularly men- l illnesses and disorders in relationship to e various circumstances in prison. That quires a different kind of mind.

Mr Winterton

825. Really you are making the claim to , and perhaps a good case, that there eds to be more research?

*(*Professor *Russell Davies.)* Yes.

826. May I ask a direct question based ain on your written evidence to us? You y there have been many complaints that ctors do not intervene to terminate Rule seclusion. It has been our impression that isoners are largely on Rule 43 by their n wish and for their own protection. Is s not the case?

*(*Ms *Staunton.)* I think that is largely the se, but we have dealt with prisoners who are not there on their own wish and who have been there for, for example, three years, eighty per cent of their time, in seclusion, against their own wish. These are the odd case and the case of difficult prisoners, but it certainly is true that there is a group of them who are on Rule 43, not on their own wish.

*(*Mr *Owen.)* Lord Avebury has done a report, which I am not sure is available to you, on the use of Rule 43.

Mr Winterton

827. Any evidence, by the way, is relevant and available to this Committee, whether it is produced by Lord Avebury or by anybody else. So that you are aware of that.

*(*Mr *Owen.)* I am aware, yes, but the point being made is certainly that it is true that the majority numerically volunteer to go on Rule 43 for one reason or another, but there is an increasing core—I think one can only say that—of prisoners who are spending lengthy periods of time on Rule 43 in the interests of good order and discipline. These are often prisoners who end up before a board of adjudication because flash-points develop within a segregation wing and there is a ghastly cycle of segregation disciplinary offences; first they appear before the board of visitors, then there is further segregation. For this category of prisoner I can speak only from my experience, because I represent this group, prison medical officers —and again it may well be because they do not have the research—do not seem prepared to say to the Board, "Look, this is really getting us nowhere. Let us think of another way of dealing with this person other than another bout of cellular confinement on Rule 43".

828. You have made the point. May we move on to another question, again referring to your written evidence. I think sometimes you do go a bit OTT, like using the phrase "many allegations", which you have. When we actually come down to it there are perhaps not quite so many as you would imply. Here you refer to a "massively disproportionate use of body belts at Wandsworth last year". Can you expand on this allegation and is there evidence that it is happening in other prisons, other than Wandsworth?

*(*Mr *Owen.)* May I deal with Wandsworth, first of all? The problem there is—and this is where one looks at the question of the extent to which prison

[Mr Winterton *Contd.*]

medical officers feel free to speak out about situations in a regime which they do not feel are conducive to health. In Wandsworth last year the Board of Visitors produced their annual report in which they expressed concern at the use of body belts in segregation wing at Wandsworth Prison. It seems to me that the doctor ought to have been speaking out about that well before the Board of Visitors decided to say it. This is really not justifiable because it seems to me that since the medical officer is required to approve every restraint by a body belt, and not all those matters will come to the attention of the Board, there really is something wrong there. If the Board is concerned about it, it is my view that the doctors ought to be as well. So the evidence is from Wandsworth. I accept that there is not evidence across the whole country. One can say it is disproportionate or disparate.

*(*Ms *Staunton.)* In that case we do not in fact know the doctors' opinion. It could have been privately they were speaking.

Mr Winterton: Thank you. I am glad you added that because I think it is helpful.

Mr Galley

829. Your evidence relating to fitness for adjudication certificates tends to concentrate on the perfunctory way in which the procedures are carried out. I think your comments, Mr Owen, were leading to questioning the propriety of doctors doing that job. You would confirm that you are concerned about the propriety of doctors doing it?

*(*Mr *Owen.)* We are concerned about the propriety, the ethics, of doctors appearing to give a medical endorsement to particular forms of punishment. We are not saying the medical service or the doctors should abdicate that entirely, in the sense of not giving advice about health implications of particular forms of punishment. We say there ought to be an input there but it is advice, at the end of the day, that the governor or the board or visitors uses to take a decision on and carries the can for it.

830. It is a management decision for the prison governor with the advice of the doctor; that is the gist of what you are saying?

*(*Mr *Owen.)* Yes.

831. Dr Kilgour, when he came to see us, was suggesting that he was reconsidering the procedure and intending perhaps to change the system so that the doctor l only to intervene if he thinks the prisone not fit for adjudication. Would that be m acceptable to you? What would be yo comments on that?

*(*Professor *Russell Davies.)* Yes, I thi that is nearly right. I think the doctor h got to play a rather bigger part in it th that. I think when some procedure adopted, under the governor's instigati he should monitor what is happening to t health of the prisoner while that is happe ing so that he does stay with it rather m than just giving advice.

*(*Ms *Staunton.)* Also there are two stag one is, before the prisoner goes in for t adjudication, whether the prisoner is not to go to the adjudication, not fit perhaps understand the proceedings, then there i second and later stage where the board visitors could perhaps more often ask fo medical opinion, specifically then a there, as to whether the prisoner is fit withstand the sort of punishment. Why concerns us is because it is a matter of t prisoner's perception of the doctor's r and trust and confidence between the p tient and the doctor.

832. Which would go back to the sugge tion you made, and many others, that t NHS ought to have a rather larger role the prison medical service?

*(*Mr *Owen.)* There is also the secon opinion argument, that if there is a dispu about whether the prisoner is fit to go cellular confinement for 56 days, under t present system I have no way of represen ing a client, of arguing with the pris medical officer to the board. I cannot a for an independent medical person to con and assess the prisoner.

Chairman

833. If you ask, as a lawyer representin are you refused? If you ask for a secon opinion are you refused?

*(*Mr *Owen.)* Yes.

834. The rules just do not allow it?

*(*Mr *Owen.)* Rule 17 of the Prison Rul says that doctors' second opinions may b sought if the medical officer so decides. Yo get a ludicrous situation often that you ca only get second opinions if you launch leg proceedings in the form of issuing a wri Under Rule 37A you can then have a rig to a second opinion, only once you hav commenced legal proceedings.

Mr Galley

835. What sort of monitoring goes on w, to pick up Professor Russell Davies's int?

(Professor *Russell Davies.)* I cannot an- er the question. I do not think any. I am t sure.

836. While somebody is in confinement, whatever punishment, there would not any continuous monitoring of their dical condition from day to day?

(Professor *Russell Davies.)* I do not think re is any systematic monitoring. I am aid I am not competent to answer. I have d to find out whether this goes on. I do t think it does.

(Mr *Owen.)* What happens is the medical icer is under a duty, not a legal duty, to ke a routine tour of the segregation wing ry day. To that extent the person is sent to cellular confinement for 56 days.

837. They do not have to make a record the prisoner's health from day to day?

(Mr *Owen.)* Not in the sense of a board at end of the bed on which they record anges on the person's mood, or whatever, . It is simply a round of the segregation ng or the prison generally to assess if neone is seriously ill. There is no detail a daily basis of how a prisoner is ponding to segregation.

838. Would that be a feasible and sensi- change to the system?

(Mr *Owen.)* Certainly, yes; it would be possible to do the kind of research that think ought to be done without that kind detailed investigation.

(Professor *Russell Davies.)* My under- nding is I think that it is only if the soner is drawn to his attention that he lly makes any close study of what is ppening. Mostly it is a purely cursory ssing through the unit.

Mr Winterton

839. Am I not right on segregation that ually prisoners in segregation are seen by doctors every day that they are in regation? I am right, am I not, on that?

(Mr *Owen.)* Yes; I have just said that.

840. I was not quite clear from that; it is ually done in every prison?

(Mr *Owen.)* Every day, yes.

841. Moving on to another part of your interesting evidence about the certification of doctors. Could you expand on your suggestion of the certification of doctors fit to advise prison management on such matters as fitness for adjudication and fitness for punishment? I put specific questions under this heading to you. Would this require particular training and why would it be any better than the present system?

(Mr *Owen.)* I think it is linked into the issue of research. What one is seeing is that we recognise that there is a certain specialist knowledge which may have to be acquired in order adequately to advise the prison authorities on this kind of issue and what we are talking about in terms of certification is that, if it is a full-time doctor at the prison, he or she ought to develop some kind of expertise and be in a position to give advice. It will only be advice. We are not saying it would be an endorsement which the governor could reject, but advice on the perils to health of segregation of a particular person any longer.

Chairman

842. Like some other witnesses who have come before us, who advocate integration of the prison medical service within the NHS, how do you see this being achieved in practice? Do you think regional health authorities can be relied on to provide sufficient funds for prison medical services, or do you really believe also it would actually lead to a better service?

(Professor *Russell Davies.)* I think the question of funding is something I am not particularly competent to expand on, except from general experience. I think special arrangements for funding have to be made. I heard what NACRO was saying about that. One way it could be done is for the prison service to buy services from the health authorities. I do not think there is any particular difficulty about doing that.

843. Would that idea appeal to you?

(Professor *Russell Davies.)* Yes, provided that the people who are bought belong to the NHS, so to speak. I noticed that NACRO made a distinction about buying the service rather than buying the people. That is an important distinction. I think it is important that the people who come into prison have belonged to a community of doctors outside prison, and although they are going to be specialised in prison medicine, it is useful, I think, that they should also have a certain amount of time doing other relevant things outside the service.

[Chairman *Contd.*]

That is quite easily dealt with by the Home Office or whoever, simply buying so many sessions of particular people's time, or full time service for other kinds of people.

Mr Winterton

844. Do you believe continuity is needed within the prison service as much as I, as a member of the community, believe that the continuity of knowing one particular general practitioner, one particular consultant is very helpful in the treatment that I might need?

*(*Professor *Russell Davies.)* I think continuity is important. I think also you have to have continuity and diversity. I know from my general practitioner friends that quite a number of patients who are extremely loyal to them do take the opportunity, while they are on leave, of getting an opinion from another partner. I think that is a very useful kind of device which is available to those outside prison. Although I think the responsibility should largely reside in a particular person's hands, I think it is very useful that there should be other opinions available.

*(*Mr *Owen.)* On continuity, the argument about continuity only applies strongly if the occupants of particular prisons are continuously there. We know a large number of long term prisoners are ghosted around the system and can spend very short periods of time in one particular prison. Shorter term prisoners may only be there for a matter of six months to a year in the vast majority of cases. The argument about continuity is less important than the arguments about variety and quality.

Chairman

845. May I take it you would not be attracted to the proposal we had from some witnesses of a special health authority to take over the prison medical services within the NHS?

*(*Professor *Russell Davies.)* I am not sure that I would turn that down completely. I think it depends on what kind of prison we are talking about. Certainly in the local prisons, thinking of somewhere like Horfield in Bristol, that ought to be incorporated into the Bristol Health Authority service. I am not quite so sure when I come to the large remand prisons like the ones in London, Brixton, Wandsworth, whether there it might not be necessary to have special health authority. I think that i matter perhaps for a good deal m exploration as to what would be the ri structure.

846. There might be problems too ir place like the Isle of Wight where you ge concentration of long term prisoners?

*(*Professor *Russell Davies.)* Yes, and th are, in a sense, national prisoners rat than local. I do think one wants to have mind all the time is that the people staff it do have close contacts with the other p of the medical community so that the Isle Wight doctors in a prison service do ha contact with the Isle of Wight doctors in other services.

847. In your paper, when you refer Holloway, you talk of the tension betwe nurses and disciplinary staff. Is there no risk, if all the nursing staff in prisons w NHS staff, of the sort of tension y described and that it would be extended all other prisons?

*(*Ms *Staunton.)* That would certainly b danger. I think there have been varic reports on Holloway, not just our repo which have pointed that out. I think pris nurses have pointed that out. The practic ities of it would be who controls access the prisoners perhaps, and that seems to what the prisoners are complaining to about, which is all I can tell you abo —who controls access to them, whether would be the nurses or it would still be t prison officers.

*(*Mr *Owen.)* Another point in the report that it is not entirely clear whether tensior the result of disciplinary control treatme or the consequence of the physical envirc ment which itself creates tensions for p soners as well.

*(*Professor *Russell Davies.)* There is argument for separation of the functio Whilst we are talking about disciplina functions, we are talking about professior health functions. They are sufficiently d ferent but I think that some distinction the staff of that sort is inevitable.

Chairman: We have had quite a sessi between us all. Thank you very much coming. We will ponder all that you ha had to say to us.

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HOUSE OF COMMONS

SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

Wednesday 5 March 1986

Prison Officers' Association

Mr J Kay and Mr A Taylor

Prison Governors' Branch, Society of Civil and Public Servants

Mr T Bone and Mr S Powell

Association of Chief Officers of Probation

Miss P I Barrett and Mr G P McNeal

National Association of Probation Officers

Mr P Bowyer, Mr R Thomas and Mr B Hampson

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Members present:

Mrs Renée Short, in the Chair

Mr Tony Favell
Mr Charles Kennedy
Mr Terry Patchett
Sir David Price
Mr Nicholas Winterton

Memorandum submitted by the Prison Officers' Association

1. INTRODUCTION

1.1. The Prison Officers' Association is a registered Trade Union. We represent the ijority of all workers in the Penal Establishments and Special Hospitals. Amongst those :mbers are Uniformed Hospital Officers, Nursing Staff employed by the Home Office ison Department, Nursing Staff in Special Hospitals and Uniformed Discipline Staff io have a responsibility to produce in Courts, inmates who would be considered as tients.

1.2. The Prison Medical Service was established by an Act of Parliament in 1774 in der to "preserve the health of prisoners in gaol". The main purpose of the Act was to event the spread of Typhus from prisons to nearby communities.

Present circumstances regarding a variety of communicable diseases demonstrate the ntinued need of that principle.

1.3. The Service has expanded rapidly since then, both in numerical proportion and ecialised needs. Apart from providing a health service for prisoners, it also provides a edical reporting service to Courts.

1.4. Specialised areas include (a) The Psychiatric Prison at Grendon Underwood, and) The provision of Baby care units at Female Hospitals and (c) Operating theatres in a w Establishments.

1.5. The Medical Service has undoubtedly been, in our view, underfunded and therefore iable to provide an acceptable standard of health care. Prison Hospital Staff have been nied, until recently, the opportunity to achieve recognised professional qualifications in rvice.

The POA have campaigned for many years in order to seek a higher standard of training r our Hospital Officer Staff. We see this as fundamental to raising the standard of health re for the inmates and also fundamental to raising the levels of job satisfaction for ospital Staff.

1.6. We join with other Trade Unions in aiming to provide Prison inmates with no less a andard of health care than they would be entitled to if they were not in Prison. We hope at the Review will result in the principle being realised in the near future.

1.7. We are aware that much pressure is being brought to bear on the Government to ke away the autonomy of the Prison Medical Service and render it responsible to Local uthorities and/or the National Health Service. This is not a view we would share and we nsider it vital that the Service remains independent. What is required to ensure the andards are no less than outside the Prison System, is that a tremendous boost to the nding may be forthcoming.

The cost of printing and publishing these Minutes of Evidence is estimated by Her Majesty's Stationery ffice at £3,240.

1.8. Further financial resources would allow the service to maintain its autonomy an the same time ensure improvements in facilities, training, equipment and status. W qualified Uniformed Hospital Officers who are trained up to a professional standard, service would benefit, as would those for whom the service is provided.

1.9. Financial resources must be separately provided for the Prison Medical Service any move towards integration with the National Health Service could only result competition for funds and resources which are identifiably scarce. It would be an un competition and many basic moral arguments would develop with regard to "who sho have the priority, the prisoner or the law abiding citizen?" The result would be a furt deterioration in medical health care.

1.10. With regard to mentally abnormal offenders, any integration with the Natio Health Service might mean that Prison Hospitals would become registered treatm centres and thus become an even bigger dumping ground for those who ought not to b prisons now.

1.11. Given the present circumstances of a rising population together with a rise in Vi Infectivity Cases (ie AIDS and Heptatitis "B"), both increased funding and independe will be essential if the inherent risks to our members are to be avoided.

The risks are certainly identifiable, but avoidance will be expensive. If there is to competition for those funds, the risks will become inevitable.

2. Structure

2.1. The Prison Medical Service is part of the Home Office and has a Director who i Medical Doctor. The Director sits on the Prisons Board which is chaired by the Direc General of the Prison Service for England and Wales.

2.2. The Director of Prison Medical Services has a Deputy and four Regional Directo All are Doctors and come under his direction. The Directorate is located in London.

2.3. Local Establishments are served by full-time or part-time Medical Office depending upon size, numerical complement or type of establishment.

At present the service is short of approximately five per cent full-time Medical Office and 15 per cent part-time Medical Officers. The figures may fluctuate and are only general guide.

2.4. Prison Doctors are also supported by part-time Specialists who visit Establishmen These include Psychiatrists who attend a few sessions per week, depending on the type Establishment and specialised needs. Visits are made by Venereologists, Physiciar Gynaecologists and Surgeons where operating theatres exist.

There is also a facility for prisoners to be escorted to Specialist Consultations outside th Prison, or, if it is more convenient, the Consultant attends the Prison. The latter is th general rule where a security risk is considered.

Dentists, Opticians and Physiotherapists and Occupational Therapists are also regul visitors to Prisons.

2.5. There is one category of Specialists for whom there is a unique rule. It is that of th Forensic Psychiatrist who holds a joint appointment with both the National Health Servic and the Home Office. This resulted from the 1964 Home Office working party on th organisation of the Prison Medical Service when complete integration with the Nationa Health Service was rejected. If it is to be considered as some form of compromise, then it the only compromise the POA could endorse.

ECOMMENDATION I

2.6. We would ask the Committee to accept our view that the Prison Medical Service main independent and that steps are taken to ensure sufficient funds to develop the ndards referred to in our submission.

3. CONDITIONS

3.1. Conditions in Prison Hospitals range from excellent to downright disgusting. We ve no intention of listing them in order of merit, but simply wish to draw attention to the cades of neglect which have produced conditions in some Prison Hospitals which would t be tolerated elsewhere.

3.2. Again, we must refer to the increase, since the early 1970's in viral infective cases ıongst the inmate population. Difficulties arising from this increase are predominantly perienced at large local Establishments where there is a high population of Remand isoners. Such Establishments are of the older Victorian type, the fabric of which has been owed to run down and even collapse.

One of the main priorities when caring for viral infective cases is maintenance of good giene and good nursing techniques. Both of these priorities are frustrated by lack of ancial and practical resources and our Hospital Officers have a creditable record in ıanaging against the odds.

Perhaps it would have been in our better interest *not to manage* and thus expose the ıdequacies resulting from years of neglect. The fact is that our members are responsible, ring people who recognise their vocational calling in spite of the conditions in which they e obliged to perform their duties.

3.3. Medical Officers must be frustrated also by the conditions of their employment and hough it is not for the POA to make their case, we cannot miss the opportunity to show r sympathy.

There are many reasons why an inmate reports sick and it is not always a physical ıtter.

Overcrowding during the past decade has led to an inner-city syndrome with subsequent ychological manifestations.

The often over-stretched Medical Officer is obliged to work at great speed and through fault of his own, could well miss vital clues which will later mean that a potential patient comes an offender against the Prison Rules.

This is all symptomatic of the conditions; is identifiable; and is avoidable with proper ovisions.

3.4. The provisions we refer to do not only include financial resources for new buildings, provements to existing Establishments and running repairs. There is a need to look at ıere financial resources come from and where they go.

Financial resources for maintenance, repair and improvements of health care units is ly a small part of the general Building and Works budget. Again, this needs to be oarately identified or the result is (as now) competition with other parts of the Prison.

The service has long been demand led and sudden announcements by Parliamentarians, rticularly the Home Secretary means that finances are equally suddenly diverted to meet ıt announcement, ie conversion of a military camp to serve as a new Penal Establishment

If there is no "new" money sub-headed for that purpose, it must come from the existing te. Too often, that means a syphoning-off of financial resources for which health care its are already competing against unfair odds.

3.5. In essence, with the present form of financing, it is impossible to apply a standar health care accommodation throughout the service. This suggests that the health provided to each individual prisoner depends upon location. That alone is totally unfa prisoners and unacceptable to those who cater to their needs.

RECOMMENDATION II

3.6. (a) All Penal Establishments should have an identifiable common standarc Health Care Accommodation.

(b) The provision of Medical facilities should be no less than that provided outs Prison.

(c) All financial resources for Health Care Units should be separately identifiec that competition does not occur.

(d) All new Establishments (whether green field or converted property) sho contain some hospital facilities, and those already provided in older exist Establishments should be improved forthwith.

4. STAFFING

4.1. Prison Hospitals are staffed mainly by uniformed Hospital Officers, except female establishments where all hospital staff are qualified nurses.

4.2. Many of the Uniformed Hospital Officers have nursing qualifications which tl have brought with them into the service. The vast majority are Officers who were initia in the Discipline Officer grade and chose to apply for training as a Hospital Officer.

4.3. A Prison Officer who wishes to specialise and become a Hospital Officer is oblig to attend a selection board. If one is successful and considered suitable one will th undergo a Hospital Officer training course.

Those who already hold nursing qualifications attend a shorter course where the ma training is on matters of procedure and administration.

4.4. We have recently pursued long-standing POA policy aimed at the provision of service training for all Prison Hospital Officers to be made available and leading tc professional nursing qualification.

We see this as being fundamental to the needs of the service and the equality of hea care.

We would expect to see an increase in applicants if the proposed future traini schedules become a reality.

4.5. The Hospital Officer grades are undermanned and it is not difficult to understa why. First of all the lack of past consideration of our many submissions regarding nursi qualifications has meant that status is being denied. Status runs in tandem with dignity a pride in one's job. Secondly, lack of professional qualifications restricts the practice o Hospital Officer and denies the patient an equal standard of medical care enjoyed by thc outside a prison.

4.6. The introduction of professional status will instil dignity for the Hospital Offic and also improve the medical health care for the inmate. It will also allow the qualifi personnel to practise the full range of nursing techniques within that qualification a encourage further specialisation.

4.7. We would also wish to see a situation where long periods of Detached Duty neighbouring Establishments are no longer necessary. This can only be achieved with tremendous increase in the present Hospital Officer complement.

4.8. We have also entered into agreement with the DPMS for integration of the male and nale Hospital Officer grades. These are long term plans which required a great deal of sion and will undoubtedly benefit the service generally. The funding of these plans will be further reason to maintain the independence of the Prison Medical Service.

In accordance with European views, we do not recognise a general Occupational ualification which differentiates between male and female nursing staff. Such a fferential does not exist in the National Health Service and except in special cumstances which will be a medical decision, we cannot see any need to separate male d female (Nursing staff) Hospital Officers in the Prison Service.

ECOMMENDATION III

4.9. (a) We urge immediate financial provision for the recruitment of more Hospital Officer Staff.

(b) We would ask the Committee to recognise the urgent need for all uniformed Hospital Officers to have the availability to attend in-service training courses which lead to a professional Nursing Qualification.

5. FUTURE OF PRISON NURSING SERVICES

5.1. In the previous section we referred to long-term plans for the Prison Medical Service d points upon which we had reached agreement with the DPMS.

5.2. If standards are to be improved, it is not only a matter of accommodation and sources, it is very dependent on the quality of the Hospital Officer staff.

5.3. If our aspirations are realised and Hospital Officers are given the opportunity to hieve nursing qualifications, we would wish to see a completely integrated Nursing rvice where all are Uniformed Hospital Officers.

5.4. This can be achieved by:

(a) Creating the conditions which would encourage present HOPD nursing staff to become Prison Hospital Officers, with no disadvantage as a result of the transition.

(b) By ensuring that all staff have the opportunity to achieve professional qualifications.

(c) By introducing a realistic financial reward for those who take the trouble to improve their professionalism.

ECOMMENDATION IV

5.5. That the points outlined in section five, are accepted as a realistic approach to ising medical care standards and lead to more job satisfaction for those who work in ison Hospitals.

6. RESOURCES

6.1. Although we have mentioned resources in staffing and in financial terms in previous ctions we feel that it needs to be dealt with more specifically as a separate item.

6.2. Whether or not our previous recommendations find favour with those deciding the ture of our service, it must be recognised that prison medical care will require fresh nding. Even if the service remained unaltered in its structure, the years of neglect have w manifest that neglect in serious shortcomings. That alone will register a need for new nding in order simply to rectify past deterioration.

6.3. The implications of our recommendations clearly bear heavily on resources o financial and staffing nature. The present method of funding is divided and comes fro variety of separate votes. The Medical Service is obliged to compete against others a therefore has little control over its own financial resources. Someone at sometime m make a decision based upon what might be considered as a priority. This can, and of becomes a personal judgment and past experience shows that Prison Medical Servi figure low on the priority list.

6.4. The recent Government initiative to provide more prison space by opening n Establishments (within the present budget) has led to severe curtailment of expenditure existing accommodation. The results are obvious in a number of older Establishme where the need for proper, hygienic, functional health care units is the greatest. The rea is that the greatest needs have received the least attention.

6.5. Financial and staffing resources will have a major impact on any consideration integrate the Service with the National Health Service.

No longer would Prison Authorities be in a position to determine how their share financial provision is spent. This would be determined by Regional or local Hea Authorities and the moral argument would ensure that the Prison Medical Service w poorly provided for. The service is in a crisis at present and any further reduction standards will eventually lead to positive risks to the community at large. Prison medi health care would undoubtedly deteriorate further as the demands created by curre communicable diseases grow.

6.6. It is again necessary to repeat that separate funding of the Prison Medical Servi will be necessary to ensure standards of accommodation, standards of nursing care, a control over the financial rate allocated to it.

RECOMMENDATION V

6.7. (a) Financial resources should be separately identified and controlled by the Pris Medical Service in order to improve and maintain standards.

(b) Any suggestion that the Prison Medical Service should be integrated with t National Health Service must be considered along with the detrimental effect would have on an already under-funded service.

7. SUMMARY OF POA EVIDENCE

7.1. The POA consider that the Prison Medical Service should remain independent an not integrated with the National Health Service (2.6).

7.2. The POA consider it essential that all Establishments should have a comm standard of health care accommodation which is no worse than that provided outsi Prisons (3.6)(a & b).

7.3. The POA consider that:

All financial resources for Health Care Units should be separately identified, so th competition does not occur (3.6)(c).

7.4. The POA consider that:

All new Establishments (whether green field or converted property) should contain som Hospital facilities, and those already provided in older existing Establishments should b improved forthwith (3.6)(9d).

7.5. We urge immediate financial provision for the recruitment of more Hospital Offic Staff (4.9)(a).

7.6. We would ask the Committee to recognise the urgent need for all Uniformed ospital Officers to have the availability to attend in-service training courses which lead to rofessional Nursing qualification (4.9)(b).

7.7. The POA ask:

That the points outlined in Section five are accepted as a realistic approach to raising edical care standards and lead to more job satisfaction for those who work in Prison ospitals. (5.5)

7.8. The POA consider that:

Financial resources should be separately identified and controlled by the Prison Medical rvice in order to improve and maintain standards (6.7)(a).

7.9. The POA consider that:

Any suggestion that the Prison Medical Service should be integrated with the National ealth Service must be considered along with the detrimental effect it would have on an ready underfunded service.

Examination of Witnesses

R JIM KAY, Assistant Secretary and MR ALAN TAYLOR, Vice-Chairman, Prison Officers' ssociation, called in and examined.

Chairman

848. We are very grateful to you for your lp with the Committee and for letting us ve your paper and for agreeing to come d give evidence to us. We would like to t some questions to you. Can I start off th training: now, in your document you commend that all uniformed hospital ficers should be able to attend in-service aining courses which lead to professional rsing qualifications; what standard do u have in mind for qualification at the d of that course?

(Mr *Kay.)* We are quite clear, in fact, at the training should be at least up to RN standard. However, if it is going to corporate all the aspects of the Prison edical Service there needs to be con-deration given to whether or not the cility could be provided to train possibly to forensic psychiatric nurses; if that uld be done we would see that as rais-g somewhat the standard of the Prison edical Service.

849. What do your members feel about e proposal?

(Mr *Kay.)* Our proposals within?

850. Yes?

(Mr *Kay.)* In fact, our proposals are based upon policies which have been made at previous annual conferences and it is obviously a mandate.

851. These come as results from an annual conference?

(Mr *Kay.)* Indeed they do.

852. I see. I gather from what you say you feel training in psychiatry is obviously very important?

(Mr *Kay.)* Indeed.

853. Would you say that it is perhaps more important than training in general medicine and surgery or not?

(Mr *Kay.)* Given the service is quite diverse anyway, there are medical aspects and psychiatric aspects to be taken into consideration. What we would not like to see is a general qualification which would debar people from paying proper attention to the various categories that need to be looked after. It would not necessarily mean all of them would reach the forensic psychiatric qualification but certainly that should be what is aimed for.

854. Do you wish to add anything? You are able to respond?

(Mr *Taylor.)* Yes, that is quite specific.

[Chairman *Contd.*]

855. If that proposal goes through for the training that you envisage, how do you think that should be given? Would it be given by seconding your members to NHS nurse training schools or would you want to see a separate training school set up; how do you see it?

*(*Mr *Kay.)* I think fundamentally we are not opposed to either provided the end product is going to be the actual thing we are looking for.

856. What would you feel would be the most convenient for the Service and for your members?

*(*Mr *Kay.)* That is really a matter for whoever provides the funding for these courses.

857. The funding may depend on the proposal?

*(*Mr *Kay.)* Indeed. We would be quite happy either way providing provision is given and staff are able to get the qualifications.

858. How many people do you suppose might be involved at any one time in one part of the course?

*(*Mr *Kay.)* Again, given we have started the process of negotiation and consulting with regard to the future of the prison nursing service, that is something that would need to be assessed at a later date. Given it is also a very demand led service, what we are hoping that the Inquiry will provide in the end is a service which is certainly no less than the sort of medical care provided for people outside the prison service. That, again, will depend upon what is seen as the best.

859. So you feel there is an urgent need to improve the standard within the service to make it the equivalent of what is provided in the hospital service? Do you see any danger perhaps in officers having been trained and then being enticed out of the prison service into the hospital service?

*(*Mr *Kay.)* Certainly not, in fact, it is quite the reverse. We would see if they got the qualifications, the job satisfaction would rise accordingly. They would be allowed to do the sort of thing they cannot normally do at the present time. It would allow us to have a more specialised service and allow those in the service to provide a better medical service for those in their charge.

860. Do you see any barriers for providing the service that ought to be provided?

*(*Mr *Kay.)* Funding, essentially.

861. Is that what it is?

*(*Mr *Kay.)* We simply feel it has be presented that way in the past. I must there are quite a few areas of agreem between us and the directorate of Pris Medical Services in that we do recognise need for further training and whether reasons for it not coming about in the p have been funding, we really cannot say b past experience tells us that may have be one of the considerations.

862. Are you representing officers in t Scottish prisons as well?

*(*Mr *Kay.)* No.

863. You are not. They, I understar have two years' training provided for hop tal officers in Scottish prisons, do you ha any knowledge of the training courses?

*(*Mr *Kay.)* Very peripheral knowledge do understand they are not called hospi officers, they are called nursing office which is a recognition.

864. You would like to be called that?

*(*Mr *Kay.)* We would like the officers be given the opportunity.

865. Do you know anything about th training?

*(*Mr *Kay.)* None other than it is I believ a secondment outside the service.

866. But you do not know what th content of the course is, have you looked that?

*(*Mr *Kay.)* Not at all.

867. I see. Are any hospital officers a present able to train for professional qualif cations of any kind? Do they have an opportunity for that?

*(*Mr *Kay.)* In their own time at their ow expense.

868. In their own time means exactl what?

*(*Mr *Kay.)* Well in time other than whils they should be at work.

869. Do many of them do it?

*(*Mr *Kay.)* I really do not know. Most o the prison hospital officers who have quali fications have brought them with them int the service. Now and again there ar specialist studies of nursing which officer do take on their behest. I think there are a few occasions when they have been assiste

hairman *Contd.*]

t I think they are small; indeed they do t make an impact on the service.

870. What representations have you ıde to the Director of Prison Medical rvices about your views on this: the need r changes?

(Mr *Kay.*) We have made these represen-ions to the Prison Medical Service before rough the Whitley machinery on several casions over the last three years and rtainly we have reached some agreement to where the future of Prison Nursing rvices lies.

871. How satisfied have you been with e response?

(Mr *Kay.*) Very satisfied, I think, re-ntly, yes.

(Mr *Taylor.*) There are indeed on-going gotiations with regard to a whole package create a hospital officer unified branch thin the Service. As you are no doubt vare within the female establishment the epartment acknowledge qualified nursing aff, the conditions of service are DHSS nditions. There is a programme which ill attempt to bring them into the unified ades thereby creating within the female rvice qualified hospital officers. We would rtainly, through our process, attempt to ave a unified service between the female id male establishment.

872. In the interests of equality and all at?

(Mr *Taylor.*) Right. If they are going to cknowledge qualified nursing grades in male prisons, we would see the same ualifications are necessary within the male risons.

873. That seems logical.

(Mr *Taylor.*) The training programme we re discussing would provide in its initial age a 30 per cent qualification, that is a ated aim of the Department.

874. What is the 30 per cent qualifica-on, 30 per cent of what?

(Mr *Taylor.*) 30 per cent of staffing vel.

875. I am with you.

(Mr *Taylor.*) It is currently 11 per cent.

876. Is it, yes.

(Mr *Taylor.*) What we would attempt to o is to get that right across so ultimately we id up with fully qualified service and by iat I mean nationally recognised.

Sir David Price

877. The Prison Medical Service has recently advertised for trained nurses for the prison service. Is this a policy you support?

(Mr *Taylor.*) Yes.

878. Do you think that there is a danger of the sort of tension that has been seen between nurses and discipline officers at Holloway developing elsewhere?

(Mr *Taylor.*) The tension developing betwen the nurses and the discipline staff? I am sorry, I do not understand that.

879. We have had evidence that there have been in Holloway problems between the nursing staff and the discipline staff?

(Mr *Taylor.*) If I could take the point, the difficulty with regard to employing nursing grades—and we represent the nursing grades; they are our members—is that on many occasions when a nurse goes about her duties she has to be accompanied by a discipline officer. There are times when the availability of that discipline officer does not exist. Therefore, yes, I suppose friction could be the right word, but not in a working capacity at all.

880. I suppose in those circumstances, then, the nursing side of what there is supposed to be happening is the part that suffers because discipline takes precedence?

(Mr *Taylor.*) That is right. What we are attempting to do in this new situation—and we are discussing it with the Department —is to recruit as many of those nurses currently serving within Holloway or other female establishments to respond to the call, so they go away, do their course, and they can function in total within that situation.

881. In other words, bringing qualified nurses within the service fully?

(Mr *Taylor.*) That is right.

882. Following on that, what is your policy towards the use of agency nurses in prisons? Do you think that agency nurses could or should be recruited to help in men's prisons when you are short staffed?

(Mr *Taylor.*) The short answer is we have a policy of not engaging agency nurses. Our policy is quite specific, arising from three successive conferences. We believe that the engagement of agency nurses by the Department is an admission of the lack of funding and resource over the years. We want a uniformed qualified service. If we allowed the continuation of agency nurses,

[Sir David Price *Contd.*]

then we would be playing the same theme on the same instrument.

Chairman

883. If, of course, you engage or use agency nurses, you are in fact diluting what you have got. But on the resources point, I think that certainly within the health service itself we have found over many years that the use of agency nurses is much more expensive than using nurses who are trained and qualified within the service and engaged full time. So that the resources argument is not one that we should let the Secretary of State get away with I do not think.

*(*Mr *Taylor.)* We would accept that.

884. They do get a lot more money than full-time nursing staff certainly in the health service.

*(*Mr *Kay.)* With less commitment.

Sir David Price

885. Can I bring you back to the question you half answered? What is your policy towards the employment of female nursing staff in male prisons?

*(*Mr *Taylor.)* It is a question that we have considered within our negotiations and within the documentation recently produced. The Department have indicated that in selective male establishments female hospital officers may be used in those units, etc. We have accepted that position, recognising of course that the GOQ would apply. It would all depend (a) upon the therapy and (b) upon the selection.

886. Would you have any basic objection to an open medical service?

*(*Mr *Taylor.)* None.

887. The same as say the Services?

*(*Mr *Taylor.)* That is quite right.

888. Female nurses and men nurses are the same, according to their qualifications?

*(*Mr *Taylor.)* That is right. In fact, that argument extends into the promotional field, because it becomes a question of GOQ. But, basically, we would have no objection.

889. Are there any changes you would like to see in the working relationships between discipline and hospital officers on the one hand and medical officers on the other? Are the relationships satisfactory in your judgment between the hospital officers and medical officers?

*(*Mr *Kay.)* Yes. I think that is very m an individual point. Some medical offi relate extremely well to their staff; t relate extremely well to the general di pline staff. Others do not. It is reall personal matter. I do not think you cc generalise on that particular point. What have seen is where medical officers supportive of the staff, then the staff ind are supportive of the medical offic Where they are not, then there is certain breakdown in industrial relations.

890. You do not draw any distinct between those who are whole-time pri medical officers and those who are p time, coming from outside?

*(*Mr *Kay.)* No.

891. It is very personal to each individ in each particular prison?

*(*Mr *Taylor.)* That is right. Dependi upon the individual medical director witl an establishment, then the staff respo accordingly.

892. But it is no more than the norm human relations; there is no structural po that can be drawn?

*(*Mr *Taylor.)* That is absolutely correct

Mr Kennedy

893. I notice in your evidence that y make the point in paragraph 7.5 "We ur immediate financial provision for the recr itment of more hospital officer staff." Bu would like to ask you for those hospit officers who are in position at the mome are you satisfied with their present p structure; do you think it is fair for examp that they are paid on the same scale discipline officers?

*(*Mr *Kay.)* They are indeed. They are n paid at the present moment on the sam scale as discipline officers; they are given specialist pay. What we are saying is that there is recognition that there is need f qualification, if they are given the availabi ity and they take the trouble to ava themselves of that course and subsequentl qualify, then there needs to be some recog nition for the time and effort they have pu in, and will then return into the service wit a higher standard of medical care.

894. Can I just clarify that with you because that seems to suggest there is a existing problem; you are saying there is differential?

*(*Mr *Kay.)* There is no recognition a present for nursing qualifications for thos

Mr Kennedy *Contd.*]

ho have achieved them in service or have chieved them and brought them into the rvice. What they do have is a specialist ay structure, the same as they have for her specialists in the prison service; it is a ery small specialist pay. What we are aying is if qualifications are then to be cognised, then the remuneration for that ffort should be reflected accordingly.

895. So you want much more in built as were?

(Mr *Kay.)* Absolutely; and the responsiility goes with it.

896. On hospitals, some of the prison stablishments that the Committee has isited have for example only a part-time P as a medical officer and no hospital fficers on duty at night. Are you satisfied ith that kind of arrangement?

(Mr *Kay.)* We are never satisfied with iat. We have had a policy from way back here many young inmates were coming om the courts on a Friday evening and ere never seen by a medical officer until ie Monday morning. That is utterly dissasfactory, obviously. The prison rules state uite clearly they should be seen within a 4-hour period. To be quite frank, if we ould reach the utopian stage where all iedical establishments had a full-time iedical officer we would be equally satiied; but we do realise the difficulties.

897. I notice that you are recommending nmediate financial provision for the recrument of more hopsital officer staff. Peraps going on from that, could I just ask ou what specific efforts have you yourelves made in the direction of improving ie staffing of prison hospitals?

(Mr *Kay.)* Constant submissions.

(Mr *Taylor.)* We have recognised over a ng period of time there is a shortage of ospital officers. If you look at the other de of it, the nursing provision within lolloway, there is a massive shortage at lolloway of nursing grades. Tying the two , it has become a question of resource. But ie resource is from a total departmental ake, if you like. We would like to see a nancial provision applied to the nursing ction of the service by the prison departent to recruit, maintain, and train.

Mr Patchett

898. You do appear to be opposed to rison hospitals becoming registered treatent centres as they make it "an even igger dumping ground", what is your policy towards specialist psychiatric units within the prison service? Would this not however solve the problem of consent to treatment?

(Mr *Kay.)* That is not a matter, in fact, which we have addressed our minds to as an Association or Executive. It was something we had to give consideration to in light of matters which had been raised by other organisations. We do see it as an issue which we would hope to come back to this Committee about at a later stage when we know what other people have to say. There is a possibility, given the present circumstances, where we are a bit of a dumping ground for those not catered for outside. This could increase, although it depends how the service is funded, it depends on qualifications of medical staff within that service and whether or not registration as a psychiatric care unit could allow us to take a full burden of that qualification.

899. In your paper you do refer to the effects of overcrowding in prisons on prisoners' mental health, I wonder if you would expand a little on that?

(Mr *Kay.)* The effects of overcrowding are very similar to any sort of inner city syndrome where people react to overcrowding. The pressures that places on them by living from day to day have been well exemplified by suicide attempts, lack of control where you cannot always keep your eye on people; the tremendous pressures on the inmate particularly on remand who does not know what will be his disposition at a later time, may not be in contact with his family. Add to all that, overcrowding and lack of time outside his cell to talk to people and move around, I do not think you need much of an imagination to understand what these pressures might do to him.

Chairman

900. There is part of your paper that I wanted to raise with you but first of all you say the joint forensic psychiatric appointments between the National Health Service and the Prison Medical Health Service is the only sort of compromise you could endorse. What would you think of joint nursing posts between local psychiatric hospitals or between those and secure units and the Prison Medical Service?

(Mr *Kay.)* I think that would be slightly incongruent with our basic principle that we would like to see a unified united service under the direction of the Prison Medical Service and not attached to the NHS. We recognise the reasons why the forensic

[Chairman *Contd.*]

doctor was actually brought in in the first place, we are not taking issue with that.

Sir David Price

901. Would you like to see movement of nursing officers between prisons and special forensic and secure units? That is another aspect of the same proposition.

*(*Mr *Kay.)* Both are our members but at the same time it is not a specific point we have managed to raise with our Executive at our conferences.

902. As of now you would have no particular objection to the principle of it?

*(*Mr *Kay.)* As of now we will take note and take it back and discuss it.

Chairman

903. If you had specialist psychiatric units within the Prison Service, would this not solve the problem of consent to treatment?

*(*Mr *Kay.)* Sorry, are you suggesting it would, I am not quite sure?

904. I am asking you, it is important because prison officers are sometimes criticised for being involved in giving medication by force against the wishes of the prisoner which, of course, is an important civil liberties problem.

*(*Mr *Kay.)* We have been in courts on these cases. Indeed, I understand what is being said and I am aware of the 1984 Mental Health Act and how it should operate but we have not given sufficient time to that and we need still more expertise and expert advice from other sources before we can really address that point.

905. Does that go for you as well?

*(*Mr *Taylor.)* Yes, indeed.

906. You have told us you want to see greatly increased funding. We have got a whole section on resources in your paper and you say that the greatest needs have received the least attention and you indicate the needs, particularly in the older prisons, and I am sure from what we have seen of the prisons we would endorse the needs for proper hygenic health care units. Could you tell us a little more about that? How you would like to see the increased funding used if it were available? Where would you like to put the money?

*(*Mr *Kay.)* Certainly as far as the medical care unit accommodation is concerned it does vary, as I say, from excellent to appalling and obviously we have got have some form of standard throughout t service. Where it is less hygenic and, in fa really not the sort of conditions where y could treat anybody with a contagio disease without some adverse affect on hi and the staff, I think we have got to start put the first funds to bring these places up reasonable standards.

907. You feel if you had a separa budget for the Prison Medical Service th would help you?

*(*Mr *Kay.)* Yes, we would not have compete with the prison vote in other are in circumstances where they come low c the list. That is not the same in ever establishment. When you come to the b old Victorian prisons everything indicate for instance at Wormwood Scrubs, th nothing was done to improve the wing tha was used as a hospital last year.

908. That, of course, would be a ver expensive exercise to do that to all the ol prisons. I am not saying it should not b done.

*(*Mr *Kay.)* It is a high priority and it something which we would be very remis not to bring before you.

909. If you had some money and yo were asked by the director of Prison Ser vices where you would place your priority where would you put the first tranche c money that might be made available?

*(*Mr *Kay.)* That is extremely difficu because, first of all, we would have t identify areas in accordance with thei priorities and that is something we woul hope to do in consultation with them an together.

910. Can you not be more specific for us Do not generalise now, this is your chance

*(*Mr *Kay.)* The difficulty is if we go int specifics it might be seen we are doing th job of the Government in identifying these areas and we have been identifying then for years. Certainly in the old run dow prisons where there is a high proportion o run down inmates and higher possibility o contagious disease coming into prison an developing within the prison, we would see it as one of the areas which should be very high on the list.

911. I cannot persuade you to tell me what you would really like to have done?

*(*Mr *Taylor.)* I think Mr Kay's explana tion was quite clear in that it is basically a

ir David Price *Contd.*]

uestion of accommodation. It is the work id hold area. If we can get that right then erything else flows from that. At the oment treatments, for instance, in any cal establishment, are divided between e hospital and the wing situation. This is a uestion of accommodation.

912. Only of accommodation?
*(*Mr *Taylor.)* No. Everything flows from ccommodation. Once you have got your ccommodation right and your staffing vel right and your qualifications right, en one stems from another. If you are king for a pace forward, where do we put e provision, I could quite easily respond y saying let us put the first money into aining. But if you have got fully trained, ualified staff throughout the service, you ave still got the problem of accommoda- on. I would put the priority on accommo- ation. It takes longer to provide accommo- ation than it does training.

913. Of course, if you had more trained aff there might be pressure to improve nditions in the prison as well?
*(*Mr *Taylor.)* Yes, indeed. Part of that cognition nationally is the fact that they ould not only be subject to the Home ffice prison department disciplinary mea- ures but equally to the UKCC. People who arried those sorts of qualifications quite early would be in an authoritative posi- on to say this standard is not good enough; nd they are the sort of people we want in e prison service.

914. Could I just put to you one other uestion to perhaps get you to indicate why ou are opposed to integration with the ational Health Service? Would you tell e Committee that and perhaps expand on and give us the reasons?
*(*Mr *Kay.)* I think the main opposition to tegration with the National Health Ser- ce is again the funding aspect. If we were tegrated, we would not only be asking for nding and resources for the staff; we ould also be asking for funding and sources for the maintenance of the fabric f prison hospitals. I would see us compet- g with regional health authorities. As I ut in my paper, my problem would be in nding whether or not they would get the ght priorities at all or any considerations all. Because that would raise a moral and hical problem within the outside commu- ty who would be saying should this vote money go to people who have broken the w or should this money not be better spent on those who in fact have chosen to abide by the law?

915. I am sure they always say that; I would not worry too much about that.
*(*Mr *Kay.)* We do not want to provide them with a view that you are asking for money you believe you need in order to make the prison service more productive in terms of reforming prisoners or whatever or providing treatment they need in order to help them when they leave prison having served their sentence and paid their debt to society.

916. Quite clearly, that is a very important part of the campaign that you are making for better conditions?
*(*Mr *Kay.)* Yes. It also needs to be remembered that the conditions inmates have to live in are the conditions where our staff have to work in.

917. Of course; that is very clear to us. Can I just put one more point? Is there any chance that your organisation will have a view on consent to treatment and psychiatric units in prisons in due course?
*(*Mr *Taylor.)* In the very near future we hope.

918. What exactly do you mean by very soon?
*(*Mr *Taylor.)* We need to consider the point. We have not had time to consult with people who have experience and expertise on the finer points or the consequences or the implications. We need to consult people, bearing in mind we have a conference coming up in May, before we can give any real consideration.

919. For instance, will it need to be an executive decision or could it be a conference decision?
*(*Mr *Taylor.)* We are on the horns of a dilemma with regard to that. We just do not know sufficient.

920. I suppose that it might arise at your conference, might it?
*(*Mr *Kay.)* Not in that respect; but it could.
*(*Mr *Taylor.)* Yes. We have nothing within the agenda specific to that proposal.

921. The time-limit has gone for the receipt of resolutions?
*(*Mr *Taylor.)* That is right. What we do have is a consultative group. From that consultative group we make recommenda-

[Sir David Price *Contd.*]

tions to the national executive. We equally throughout the membership seek returns on specific proposals; and that is the process that certainly today we are discussing before we can make our submissions. We have definite views, but it would not be proper to express those views as a group until we had cleared them, because that is the whole question of being a democratic union.

922. Of course; I understand that. So might be possible that something w emerge from your meeting then?

(Mr Taylor.) I hope to be in a positi very shortly to make a positive response.

Chairman: Good. Thank you very muc we are very grateful to you.

Memorandum submitted by the Prison Governors' Branch, Society of Civil and Pub Servants

THE REPRESENTATION OF GOVERNORS

1.1. The Branch represents over 95 per cent of Governor Grade employed by the Pris Department of the Home Office. Our members are responsible for the management penal establishments in England and Wales and the residential staff training establis ments. Some of our members work in the Regional Offices and Headquarters organisatio

1.2. The Branch has always been faced with considerable difficulty in representing t views of Governors. We have complex and unusual conditions of service to negotiate. T Home Office also expects the Branch to respond on matters of professional interest. O membership is geographically split up, making the co-ordination of views a maj undertaking.

ABSORPTION OF THE PRISON MEDICAL SERVICE INTO THE NATIONAL HEALTH SERVICE

2.1. It has been argued that the Prison Medical Service should be absorbed into th National Health Service. The main reasons advanced in support of this argument are th the Prison Medical Service is not sufficiently independent, secondly that it is isolated fro developments and practices in the National Health Service, and thirdly that absorption int the National Health Service would improve the resources available to the medical servic in prisons.

2.2. We do not agree that the Prison Medical Service is isolated. As the majority c medical and part-time medical officers run, or are part of general practices outside, and i view of the Prison Medical Service's heavy dependence on the employment of visitin consultants, isolation is extremely unlikely.

2.3. In our view even if the Prison Medical Services were absorbed into the Nationa Health Service many large prisons would still require a full time medical officer and th problems of these medical officers feeling separate from the medical profession outsid could well remain.

2.4. We are not convinced that greater resources would be available if the Prison Medical Service were absorbed into the much larger National Health Service. We believe that the general standard of treatment and hospital care in prison is very good and tha prisoners frequently receive more prompt attention than members of the general public using National Health Service facilities outside. The Prison Medical Service has free acces to equipment, specialist and hospital facilities of the National Health Service. In ou experience it makes full use of these facilities.

2.5. Suspicions of the Prison Medical Service are, however, in our view inevitable Suspicion concerning what happens in prison generally is a fact of life and emotive issue such as the use of drugs against a prisoner's wishes are bound to arouse controversy.

2.6. We are firmly of the opinion that the Prison Medical Service has nothing to hide but must be prepared to be open and should actively seek to win public confidence.

2.7. For these reasons we would recommend that the Prison Medical Service and its operations should be subject to independent inspection.

2.8. The inspectors should be professional medical staff not employed by the Prison Department. They would report on such matters as medical standards, professional ethics, organisation etc.

Access by Prisoners to National Health Service Doctors and Dentists

3.1. Prison Rule 17(4) gives an unconvicted prisoner the right to request the services of a registered Medical Practitioner or Dentist. This rule does not apply to convicted prisoners. Rule 37A (3) allows for all convicted prisoners who are party to legal proceedings and subject to any directions of the Secretary of State to be examined by a registered medical practitioner in connection with the proceedings. We believe that this rule should be extended to include any prisoner without qualification but still subject to the directions of the Secretary of State. This measure would allow greater flexibility in difficult cases and is consistent with the sentiment that the Prison Medical Service has nothing to hide.

3.2. We also believe that all prisoners should have the right to unfettered correspondence about relevant medical matters with their general practitioner or any registered medical practitioner or dentist who has been treating them outside.

Full Time Medical Officers

4.1. The Governors Branch would wish to record its belief that the Prison Service is well served by the Prison Medical Service and the many excellent full time Medical Officers who have worked and are working currently in our prisons. The full time medical officer has an important role to play in relation to the whole prison. The importance of this role should not be overlooked.

4.2. There is a danger that the specialised professional knowledge of the full time medical officer and the existence of a separate Prison Medical Service structure can cause conflict when health matters are involved in areas of general local management and policy. Team work and co-operation are important in any organisation but in establishment like prisons where a major operational crisis can occur at any time the management structure must be clearly defined.

4.3. It must be clearly understood that the medical officer is responsible to the Governor for the provision of medical and nursing services and for providing advice to the Governor on all matters affecting the health of staff and prisoners. He is not, and cannot be, an autonomous manager of the hospital.

Part Time Medical Officers

5.1. The Governors Branch is not satisfied that sufficient consideration has been given to the role of part time medical officers in those prisons without a full time medical officer post.

5.2. In our view a part time medical officer should be responsible for the daily treatment service and on-call arrangements but that there is a case for the full time medical officer of a nearby establishment having overall responsibility for medical services in smaller prisons. We believe that this is a matter for urgent review since there is much confusion in some prisons concerning the role of the part time medical officer.

Hospital Officers

6.1. The Governors Branch is well satisfied with the general standard of nursing

provided by hospital officers. We do not belive that it is necessary for them to be trained SEN standard. We would, however, recommend that hospital officers be given m training in the care of mentally disordered offenders. We are aware that hospital offic themselves frequently feel unqualified to handle mentally disordered offenders and beli that this problem could be considerably helped by more training in this specialised fie

6.2. We are of the opinion, however, that considering the lack of formal training hospital officers relative to nurses in the National Health Service, it may be wise to revi the numerous paid specialisms undertaken by hospital officers such as Compounder a Dark Room Technician, to ensure that the qualification is adequate.

Nurses from Outside

7.1. At present the employment of National Health Service trained and agency nurse confined to the large hospitals at Wormwood Scrubs and Liverpool and to the surgi units. We believe that this policy should remain and would see the introduction of nur from outside into prisons as a retrograde step. Retrograde, on the grounds of securi efficiency and from the standpoint of integration.

Provision of Chiropody

8.1. Governors in long term and dispersal prisons have identified chiropody particula as a continual source of prisoner complaints and administrative problems. Chiropody is n a recognised specialism for a hospital officer and it would seem to be the case that there no consistent policy concerning the use of registered chiropodists as visiting consultant

Mentally Disordered Offenders

9.1. For many years now the Governors Branch has been arguing for the removal mentally disordered offenders from Prison Service establishments.

9.2. No one is exactly sure of how many mentally disordered offenders there are prison at present but in 1981 a census carried out by the Prison Medical Service indicat that at any one time two per cent of inmates are so mentally disordered that they may me the criteria set out in the Mental Health Act for detention in hospital for treatment.

9.3. We are fully aware that there has been a reduction in the facilities which previous existed in the National Health Service to deal with seriously mentally disordered offender We are also aware, although we have less sympathy with this reason, that some nursin staff have become increasingly reluctant to undertake the care of such people.

9.4. While we acknowledge that there has been some improvement in the number c places available in special units of National Health Service hospitals, this improvement ha been painfully slow.

9.5. The Governors Branch believes that only drastic action can resolve this situatio We would advocate that the cost of holding mentally disordered offenders be charged t the National Health Service. This would create a financial incentive to the National Healt Service to provide the proper service themselves and to keep the population in prison a low as possible. There is nothing new about charging other authorities for keeping peopl in custody. We already charge the governments of the Isle of Man and the Channel Island for any of their prisoners we hold.

Psychopathic Offenders

10.1 The report of the Committee on mentally abnormal offenders (Butler Committee published in October 1975, concluded that prisons should have a clear responsibility t cater for offenders with dangerous anti-social tendencies who are also psychopath Although the Government decided not to accept all the recommendations proposed by th

Butler Committee, in practice prisons cater for many psychopathic offenders and there appears to be no realistic alternative.

10.2 The Butler Committee also concluded that there was a need for a controlled programme of experimentation and research to establish what kind of regime produced the most encouraging results for psychopathic offenders. We would endorse this recommendation but are not aware of it having been implemented. In our view it should be implemented.

10.3 In the meantime any prison or unit which is holding identified numbers of psychopathic offenders must be provided with a high staff to inmate ratio. At present the main aim must be to minimise acts of aggression and indiscipline and to ensure the safety of staff.

Summary of Recommendations

1. The Prison Medical Service should not be absorbed into the National Health Service.

2. The Prison Medical Service should be subject to independent inspection.

3. Subject to any directions of the Secretary of State any prisoner can be examined by a registered Medical Practitioner or Dentist.

4. Prisoners should have the right to unfettered correspondence with their GP or any registered Medical Practitioner or Dentist who has been treating them.

5. The Medical Officer's place in the management structure of a prison must be clearly defined.

6. The role of the part time Medical Officer in establishments where there are no full time posts should be reviewed.

7. Hospital Officers should be given more training in the care of mentally disordered offenders.

8. There should be no extension of the present policy of employing nurses who are not Hospital Officers into other prisons.

9. Provision of a chiropody service in long term and dispersal prisons should be examined.

10. Mentally disturbed offenders should be removed from prisons.

11. Research into the most appropriate regime for psychopathic offenders should continue and in the meantime all prisons or units within prisons which hold dangerous and aggressive psychopaths should have a high inmate/staff ratio.

Examination of Witnesses

MR TERRY BONE, Chairman; and MR SID POWELL, Secretary, Prison Governors Bran Society of Civil and Public Servants, called in and examined.

Chairman

923. Thank you very much indeed for submitting your written evidence. In your paper that you sent us you argue that even if the prison medical service was part of the National Health Service, many large prisons would still require a full-time medical officer. What do you think the prison medical officer would be doing if you were integrated into the National Health Service?

*(*Mr *Bone.)* What is often forgotten in fact is that much of the medical support within the service is provided by the National Health Service; many medical officers are part time and belong to the National Health Service. But we would not be arguing integration with the National Health Service. What we want to ensure is that there is greater control within the prison service of the medical facilities which are provided. In many ways this can only be done by a full-time medical officer.

924. So you want a full-time medical officer to keep an eye on the doctors who are working within the service who are now part time and on loan from the National Health Service?

*(*Mr *Bone.)* Yes. I think keeping an eye on people has certain connotations with which we would not necessarily agree. What is essential is that part-time medical officers do become full time in the sense of devoting their energies to the needs of the prison service. We consider that this process would be assisted by support from full-time members of the prison medical service.

*(*Mr *Powell.*) There is one aspect of prison medical life that at the moment and certainly in my experience over 30 years has not been fulfilled in anything like the degree it should be fulfilled. I am talking about the research areas as to what the stress of imprisonment causes both for staff and for inmates. I am sure that if there was a sufficiency of medical officer staff, then the degree of research that was carried out internally in prison service establishments could be improved tremendously. That in the longer term would have a direct impact on the size and nature of the future population.

925. You also say in your document th you recommend that the prison medi service and its operations should be subj to independent inspection. What sort independent inspection do you have mind; by whom?

*(*Mr *Bone.)* I think ideally by a qualifi medical team. It may well be part of t prison inspectorate which is independent the prison service as such. But the actu constitution of that body, I think cou be the subject of negotiation. But think it is important that the medic aspects of the service are independen inspected.

926. Would your proposal mean th they would be absolutely independent?

*(*Mr *Bone.)* It is a matter of degee. I thi absolute independence is almost impossib to achieve, I suspect. But as part of th prison inspectorate team, then I think could be as independent as it is likely ev to be.

*(*Mr *Powell.*) What you need to appre ate is that at the moment not so much th medical officer element of the prison med cal service but certainly the hospital offic element of the prison medical service is as were subject to inspection by a group people who inspect prison officer grad across the board, and they do not have ar particular expertise or skill in the medic field. So far as the prison medical service concerned, they are subject to inspection b the Home Office inspectorate who equall may not be, indeed probably are not, skille or have any expertise in the medical field. we are going to look to provide an improve service, it seems to us that that kind of a inspection ought to be backed up by th medical knowledge, experience and exper tise that clearly can make qualified judg ments about what the examination ha produced. We are not satisfied at th moment that is the position.

927. What about the commission set u under the Mental Health Act; do you thin that might provide a pattern?

*(*Mr *Powell.*) That certainly has possibili ties, particularly so in respect of the men tally disordered people we have to lool after and probably the psychopathic peopl we have to look after. That suggestio

Chairman *Contd.*]

rtainly would not, I think be opposed by ır side of the house.

*(*Mr *Bone.)* The most important thing is ɔt so much the method of inspection but ısuring there are standards which can be ıstified to Parliament and to the public enerally.

Sir David Price

928. You see that also being a form of ssurance to the world at large?

*(*Mr *Bone.)* Absolutely; and so it should e.

Chairman

929. Would you feel that if such a ɔmmission—let us call it a commission in ıverted commas for the time being because e do not know what the set-up would e—if it were provided would be a body ıat could deal with medical complaints, ıedical problems, within the prison service bsolutely independently?

*(*Mr *Bone.)* It is another aspect of the ıspection which could be provided ırough that kind of body, yes.

930. That is what you would wish to see?

*(*Mr *Bone.)* Yes. We would like also the ossibility of all convicted prisoners as well s unconvicted having access to GPs outide of the prison itself. That would help in ıat direction as well.

Mr Kennedy

931. Can I follow up on that very last omment? The phrase you use in your ubmission is that all prisoners should have he right "to unfettered correspondence" bout relevant medical matters with their GP or any doctor or dentist who has been reating them outside. You are obviously ot sufficiently satisfied with the position at resent. Can you just enlarge on it a bit? What exactly is the position, and what is the ıain source of your concern?

*(*Mr *Powell.)* Prison standing orders at the ıoment do impose some restrictions on the ind of communications and contacts vhich inmates can have with medical practitioners outside who have been treating hem in earlier times. What we are saying is f it is appropriate—and it is because prison ules recognise it as being appropriate—for nconvicted prisoners to have that kind of ccess, there is no justification in our view or constraining the same sort of access rom the convicted population. Part of the eason for that and part of the reason for ur stance is that it is in line with our general philosophy that the prison medical service has nothing to hide. The more open we are in our total dealing with the community, then the more widely we are likely to get a more balanced approach and realisation of what is happening in prisons.

932. Can I just ask you to clarify it a bit further in my own mind when you say the right to unfettered correspondence quite independently of anybody within the prison; they would not be seeing the exchanges going backwards and forwards?

*(*Mr *Powell.)* We have the same sort of situation now with communications with legal representatives. There is the overriding factor subject to the Secretary of State's ruling. Clearly, the fine detail of how that would be implemented would be dependent upon the stand the Secretary of State happened to take. But, generally speaking, our line would be yes, let us make the lines as open as possible.

Sir David Price

933. That takes us on to something you have already hinted at; that is your suggestion that Rule 37A(3) should be extended to all prisoners for a second opinion. Could you just explain a little bit more to us how you see that working?

*(*Mr *Powell.)* One of the sources of friction within the prisoner community is in this very area. They from time to time are dissatisfied with the treatment they receive. It seems to us that if that is the case, whether we accept it is justified or not, and they have that unfettered access to the outside medical service, then this should help to lower some of the tension that we have from time to time in prison. So that is part of our reasoning behind it.

934. Can we move on? You accept, I think, that there may be conflict between a prison medical officer's medical and his managerial role, but stress that the prison medical officer cannot be autonomous and must remain responsible to the governor. Could you just explain to us why you regard this as so important?

*(*Mr *Powell.)* Yes, indeed. It would be easy to spend a great deal of time talking about this area. If I can give one example, the part-time medical officer who because of his own reasons external to the service wants to come in and do his medical work within the prison say at some rather unusual hour in the afternoon; this is not uncommon; and there is a need—it is essential in fact—in terms of managing

[Sir David Price *Contd.*]

prisons that they fit into the organisation that we have within the prisons. Just following through that example, there is a need for medical officers to examine prisoners before they go on adjudication. If that is going to be done late in the day, then clearly that disrupts the organisation in the prison. It is very expensive in terms of keeping people waiting to see the medical officer in isolation or totally independently of the organisation of the prison; it is quite wrong, I think.

935. You do not see this managerial role as affecting the nature of the medical care given to prisoners and indeed the relationship of the traditional doctor/patient relationship?

*(*Mr *Powell.*) Not at all, No. In fact, quite the reverse, I think. We would be very reticent indeed to involve ourselves as the operational managers of the service in medical decisions; that is not our role.

936. But it has been suggested to us by some witnesses that the ordinary relationship between doctor and patient can be prejudiced; the medical officer is not just a doctor, he is also part of the prison system?

*(*Mr *Powell.*) Yes; there are advantages to that. The prison medical officer does understand the organisation and can look at individual illnesses of whatever kind in the context of the environment in which the person actually lives. I think that is likely to be advantageous to the treatment of that particular individual, that being said as a lay person. If we are talking about conflicts in this, I think the conflicts come when decisions are being taken which have certain medical connotations or impacts and they overlap operational aspects which require decisions. Certainly in my own experience I can think of occasions when this has happened. The overall charge and responsibility for running the prison rests in standing order terms and in the statute with the governor. Clearly, the governor has to make decisions with that responsibility very much in his mind. Where a medical officer wishes to advise a governor it is a very foolish governor who does not take that advice; there have been in the past occasions when that has been the position; and the governor has felt the need to refer those decisions beyond his own medical officer, in other words to a higher authority. So, yes, there are the makings of a degree of conflict there. But we stand by our position that the overall charge and managerial charge of the prison must remain in a properly defined line management sense; and it would quite wrong, in our view, to run in paralle medical responsibility, rather than hav the medical services as part and parcel the whole compact of prison manageme

937. So you would draw a parallel h to the armed forces where you have separate medical line, technically, but y have vertical responsibility?

*(*Mr *Powell.*) Yes, indeed. I mean a pris is an organisation which has to function a total organisation. If we start hiving specialisms, whether medical, education or whatever else, then it becomes an u workable organisation.

938. So it is really almost inevitable the nature of prisons; there is at lea theoretically a conflict between the doct and the prisoners in his traditional respon bility to his patients; potentially, that there; and it is inevitable and it is part of t prison service?

*(*Mr *Powell.*) The potential is always the for conflict; that is true. But I would n want to over-emphasise the degree of con ict that takes place; it is very, very minim Indeed, in my experience certainly medic officers and governors do work in a coh sive team spirit sort of way. So I would n want to over-emphasise the conflict el ment; but yes, potentially it is there.

939. But you think in practice it is rare

*(*Mr *Bone.)* It is indeed.

Mr Kennedy

940. Can I turn to the part of you evidence that deals with part-time medica officers? You express concern there abou the part-time medical officer in the smalle prison establishments; and you say that it all right for such a person to be responsibl for the daily treatment service and on-ca arrangements but think beyond that ther should be a local senior medical officer or full-time medical officer rather of a nearb establishment having overall responsibilit for the medical services in a smaller prison What do you say to the argument that i fact those facilities or services would b already overseen by local senior medica officers?

*(*Mr *Powell.*) It is true they are in part; w want to see an extension of it.

941. So it is sufficiently serious then fo there to be an urgent review?

*(*Mr *Powell.*) I would not quite put it like that; but I think there needs to be a re-

[Mr Kennedy *Contd.*]

finition of the volume of the task that is ing given to supervising medical officers; other words you perhaps need to look at e number of establishments they have ersight or responsibility for. I hark back the point we were making earlier. One of e reasons we would argue this fairly ongly is the research point that I was aking earlier.

942. But you did say it is a matter for gent review. How urgent is urgent?
(Mr *Powell.*) If one looks at the service as whole, then this clearly has in my view ayway a lower priority than the really gent tasks.

Chairman

943. There are degrees of urgency?
(Mr *Powell.*) Yes.

Mr Kennedy

944. Have you had reports from your embers in this kind of situation in smaller its of serious difficulties?
(Mr *Powell.*) Yes, there are certainly casions from time to time when difficul- es crop up. I have mentioned one this fternoon, i.e. the difficulty that some gov- nors have with part-time medical officers tting into the total organisation of the rison situation. Again, I would not want to mphasise that difficulty, but it does exist om time to time. We need to recognise it nd it needs to be resolved.

945. Just to clarify it further, quoting xactly, accepting urgent review is not in lock capitals, as it were, you say: "There is uch confusion in some prisons concerning ie role of the part time medical officer." Vhat exactly is the nature of the confusion f the role you are referring to?
(Mr *Bone.*) There are problems in terms f the line management element of it. The overnor at the moment is involved in the nnual reporting procedure of medical offi- ers on a full-time basis; as far as part-time fficers then clearly it is more difficult in rms of being able to make a judgment bout somebody who may only be present or a few hours a week. There are difficul- es in terms of integrating these part-time eople into the organisations we have. We eed to make a judgment about appropria- eness of the annual reporting procedure. Vhat we would be saying is governors ould be involved and make a non clinical dgment about the effectiveness of the erson in the organisation.

946. I think I was a bit clearer myself before I started pursuing the line of questioning. I do not understand how that clarifies it, it casts more seeds of doubt in my own mind about the nature of the problem. You seem to say there is insufficient time to amass a firm, proper judgment but you are saying in the non medical category who will contribute quite significantly to that judgment?
(Mr *Bone.*) Let me see if I can clarify that point. In terms of the governors' responsibility for the organisation of the prison, there are particular difficulties with a part-time medical officer in that, as I say, he may not be there for more than a few hours a week but nevertheless a judgment has to be made about his contribution, his effectiveness to the total organisation of the prison. That is why we would want governors to be involved in that process because a judgment has to be made on the basis of that effectiveness or lack of it in some cases.

947. That judgment would be helped by having the overseeing facility?
(Mr *Bone.*) Indeed, yes.

948. Why are you so opposed to further recruitment of National Health Service trained nurses into the prisons?
(Mr *Powell.*) In part the POA answered the question in a way we would want to answer. First of all, I think the Chairman made the point; agency nurses are an expensive habit and certainly we would not want to go along the line of employing trained hospital staff for the reasons the POA gave to you. Secondly, it is a common problem, certainly in the female side of the service where agency nurses are used fairly heavily, for agency nurses to rotate because they are subjected to agency decisions to rotate and, therefore, you get a lack of continuity. The third point that needs to be made, and again made by the POA, when we are talking about agency nurses very often we are talking about people not trained in the security or control field and there are occasions when in order for the agency nurse to fulfil her function she has to be accompanied by disciplined staff; in our view that is wasteful.

949. You mentioned it being retrograde for those reasons: security, efficiency and from the standpoint of integration, could you clarify the integration point?
(Mr *Powell.*) The integration relates to the relationships because agency nurses come in with a totally different approach to

[Mr Kennedy *Contd.*]

a custodial situation than somebody who has been trained in nursing in a custodial role. Therefore, what happens is you get an agency nurse who interprets her role more heavily or more predominantly in the medical field, sometimes to the expense of the control/security angle of the custodial element. As a consequence of that, the difficulty then arises because female discipline staff particularly react to what they perceive to be a wrong degree of treatment being given by the agency nursing staff and that is where the integration problem actually occurs.

950. The critic or cynic might say what you are really saying is they are being too caring?

(Mr *Powell.*) I would hope you do not interpret it in that way.

Mr Kennedy: I do not, the critic might.

Chairman

951. Could I clarify something you said in reply to my colleagues about part-time medical officer? The part-time medical officer who goes into the prison at different times is trying to resolve whatever problem has arisen. You might say he is doing a remedial job if that can be dealt with. Are there any other serious difficulties with them coming in from outside?

(Mr *Powell.*) There are a number of difficulties actually because the part-time medical officers in general terms also run practices in the National Health Service too.

952. Yes?

(Mr *Powell.*) Clearly they are available at the demand of the outside population in respect of their own practices. Now, if there had been, for example, a maternity case overnight then clearly they are not fit to go in without some kind of rest and, therefore, that again affects the organisational part and one has to recognise these are problems that part-time medical officers have to cope with. They cope with them in their own practices, but it becomes more difficult in the ordered community of the prisons.

Sir David Price

953. What is the difference? Why do you think it is any different inside prison?

(Mr *Powell.*) It is one thing to get a set of patients waiting in the surgery outside where people are free to choose whether they stay or not, it is another thing to get prisoners sitting in a surgery in an establishment where they do not have that freed and are subjected to a number of ot frustrations that do not happen generall

954. Really you are saying they getting a better service than the comr nity?

(Mr *Powell.*) In some respects that is tr

Chairman

955. You do say part-time medical o cers should be responsible for daily tre ment services and on-call arrangements I there is a case for medical officers so you not clear about what it is you want?

(Mr *Powell.*) Yes, what we are saying the context as you are reading it, Chairma is if we have only a part-time medi officer in an establishment, generally spea ing these establishments are smaller esta lishments and they do not have the ad tional support staff of senior grade in t same establishments, in other words wh we have usually is perhaps a part-tir medical officer with one or two hospi officers. These hospital officers work t shift system so you have only the one anc there is a medical problem arising, a suici attempt or something of that order, he clearly in the position of having to conta his part-time medical officer who may anywhere before he can make any jud ment about what the case demands. The retically the hospital officer does not have diagnostic function, in practice they ha diagnostic functions and carry them o well too. Theoretically they do not have th function. There is this difficulty of cor munication.

956. Do you have any reports from wh happens in Scottish prisons?

(Mr *Powell.*) No, we do not represer Scottish governors. They have their ow separate organisations.

957. They operate that system. Perhap it seems to me, you might have som contact with your opposite numbers i Scotland, see how it works and what th snags are?

(Mr *Bone.*) Yes, indeed.

958. My last question is one which i very interesting. You referred to the pro vision of chiropody within the prison ser vice and you say this is a continual source o prisoners' complaints and administrativ problems; why is that a particular proble within the prisons? Is that a proble prisoners come in with or acquire within th

hairman *Contd.*]

son? What are you doing to create such comfort to the prisoners' feet?

(Mr *Bone.)* I think principally both. rtainly a number of prisoners arrive in r establishments with quite severe prob-ns in this area.

959. Feet particularly you mean?

(Mr *Bone.)* Feet particularly, yes, with ne individuals

960. What have they been doing to get ose problems—on the run?

(Mr *Bone.)* That is one possibility, cer-nly—things like athlete's foot which has ver been treated outside and which the rsons themselves do not give very much re to at all. This is one example. I think u can broaden it beyond this to the wider edical sphere as well. But in terms of the iropody area, then we have these people riving and they do need quite detailed d elaborate treatment on occasions; and e service is not there to provide it at the oment.

Chairman

961. Who does in fact provide care for ese people?

(Mr *Bone.)* It is organised again by the edical service.

962. It is either done or not done; it is not ell organised?

(Mr *Powell.*) No.

963. You do suggest that the service ight be provided by visiting chiropodists; ut they are in very short supply outside. I ean I do not know where I would find one I wanted to; we do not seem to be training em any more.

(Mr *Bone.)* This is precisely our point. hat we are saying is chiropody is not a cognised specialism within the hospital fficers that we have. This perhaps points a need for further training. There is in y view a greater emphasis in the training nse to be placed, but this does point up a ed for a further aspect of training to be ven to the hospital staff; and partly it is flected in your own experience. If outside ou want a decent chiropodist, you have ry great difficulty finding them.

Mr Winterton

964. You mentioned athlete's foot as being one of the major problems. Surely that is merely a matter of hygiene, cleanliness, and straightforward treatment. Is that really worth hammering? Are there not other matters which are more relevant and important which need specialist care?

(Mr *Bone.)* There are two points. First of all, people coming on reception have this problem; it has got to be dealt with. Whether we accept it or not there needs to be a medical service to provide that. Secondly, some of the conditions in our prisons in fact contribute to that kind of problem, because they are not in a position to bathe as regularly as they would like. This is why we need to be hammering the point strongly about systems and standards.

Chairman: That concludes our questions to you. Thank you very much indeed for your help; we are very grateful.

(Mr *Powell.*) One of the things that we did not cover in our written evidence, partly because it has only really come into the arena in a real sense in recent months, relates to the Crown immunity in the health and safety area. We have as an organisation some pretty strong feelings that Crown immunity should be removed; and it is in line really with our general stance on standards across the board. Because although we are containing ourselves today in terms of the medical service, clearly if you look at standards in prisons and health and safety regulations in prisons and you look at heating, lighting, cell space, the ablutions area, that kind of thing, they all in our view have some impact on the demands on the medical services. If you could find in your Committee it fit to support that sort of general line, to remove the Crown immunity, that is something we would urge upon you.

Mr Winterton

965. I hope you understand the resource implications that may be involved?

(Mr Powell.) We do indeed.

Chairman: Thank you very much for putting that point to us; we will certainly bear it in mind.

Memorandum submitted by the Association of Chief Officers of Probation

1. The Association of Chief Officers of Probation is pleased to be invited to make t submission and welcomes the opportunity to comment upon this important subject.

2. The prison population has now exceeded 48,000. This places substantial press upon the Prison Medical Service, especially in some local prisons. Remands for medi and psychiatric reports are time limited and the resources of this service are finite. Wi use of the powers provided in Sections 35 and 36 of the Mental Health Act 1983 expanded in the Home Office Circular 71/1984 Annex para 24, setting out the role of Prison Medical Officer in referral) could offer a little extra leeway in some cases.

3. Our probation service observations suggest that in contrast to doctors a psychiatrists with whom we work in the community, prison doctors seem to have li independent information from probation officers or other sources, to assist them preparing reports for courts. Nor do they seek information from such sources. Intervie with the remand prisoner are often of short duration, seldom exceeding half an hour.

4. Psychiatric and medical reports for courts often arrive with the offender. There little, if any, opportunity for discussion with the probation officer preparing the Soc Inquiry Report, even by telephone. Both Prison Medical Officers and probation offic should work to improve consultation for the benefit of the prisoner.

5. Prisoners remanded for medical or psychiatric reports are usually in the remand wi of the establishments rather than the hospital. This does not allow the medical staff observe prisoners' behaviour in a methodical way during the same period.

6. We recommend that only medical officers with psychiatric qualifications should wr psychiatric reports.

7. We recommend that a regional Forensic Psychiatrist should be appointed on a joi appointment basis. Where such appointments have already been made, the quality service to the remand prisoner and liaison with the probation service has improv markedly.

8. We recommend that the quality and selection of medical officers should be improv by the incentive of forensic specialist status and recruiting younger more recently qualifi specialists.

9. The Governor, the chaplain and the Prison Medical Officer are the traditional thr statutory officials of a penal establishment. The doctor's position can lead to an assumptio of medical infallibility. He is seldom challenged in his judgements and therefore h considerable power. We recommend that the Prison Medical Officer's relationship vis-a-v the Governor should be reviewed. It should be more in line with the joint accountability the Education Officer or probation service.

10. Should the Prison Medical Officer be employed direct by the prison authorities as present? Does this ever create a conflict of interests? To whom are the Prison Medic Officers accountable? We recommend that they should be part of and accountable to th National Health Service. By this means the prison medical services within a pen establishment could be viewed as a department of the local general hospital. The pris doctor would have professional responsibility to medical colleagues and supervisors at th hospital, with operational accountability to the Governor.

11. Hospital staff are caring and well motivated officers. Few have any nursin qualification which would be accepted outside the prison service. Many hospital staff hav to deal with disturbed mentally ill patients, yet very few have any mental nursin experience or qualification. The existing Prison Department training seems totall inadequate. Staffing levels at present limit the opportunity for further training aft appointment.

Hospital nursing staff could be drawn into the prison hospital and existing hospital officers could be released to undertake professional training.

It is recommended that all hospital officers should be trained to obtain at least SEN if not SRN. At least one hospital officer should be a state registered nurse in each prison, possibly with the added qualification of registered mental nurse.

12. Each prisoner should be medically examined on reception. In practice in many institutions the doctor has a limit of two hours which he must share with others who are part of the reception process. Any examination must be cursory when 20 30 prisoners are seen during this time. In some establishments if there is no doctor available at that time a prisoner may see a hospital officer who is unqualified to make a medical diagnosis. More time is necessary to undertake reception medical examinations.

13. Transfer to the prison hospital is a process which may not only be governed by medical need because of staffing limitations in the hospital, especially at night and weekends. At these times the hospital may not be sufficiently staffed to cope with prisoners who because of mental illness or personality disturbance may be violent and difficult to handle. These persons are likely to be contained in the segregation unit. Wing prison officers frequently claim that they deal with more prisoners with psychiatric problems than the prison hospital. From our observations this could be true.

14. It has been suggested that sedative medicines may be used to control behaviour rather than to cure ills. We cannot comment upon that. We can say that when statistics were published about drug doses in various penal establishments they did indicate a high level of drugs given to prisoners in some prisons; whether it was justified or not one does not know, but it was true that after they were published subsequent figures showed a considerable reduction. Some prisons use sedative medicines infrequently and with great care. There are wide variations reported, these issues need to be monitored.

15. A significant number of young people remanded in custody or sentenced to imprisonment are addicted to drugs. They require carefully planned withdrawal, with close medical supervision and specialist help. Where the Prison Medical Officer has insufficient specialist knowledge, it is recommended that liaison with outside facilities may provide the knowledge and skills required. Such a scheme has been developed between Stoke Heath Youth Custody Centre and St Georges Hospital, Stafford, where Dr Matten works as a consultant to the prison. Such arrangements encourage not only the correct medical assistance but also make possible education, counselling and resettlement planning to be related to these problems during the prisoner's time in the establishment.

16. Similar programmes need to be designed for those with drink related problems. They require the co-ordinated work of the Prison Medical Officer, Education Officer, probation staff and those uniformed staff who may be trained to assist with this work. Improved health and better understanding and control of the problem will, in some cases, enable the prisoner to use the community based resources upon release.

17. An excellent report was published by HM Inspectorate of Prisons in May 1984, entitled "Suicides in Prison". About a dozen Prison Department Instructions concerning suicide by prisoners have been issued. The three of primary importance are Standing Orders 13 (101) and 13 (102) and Circular Instruction 39/1973 (amended 1981). The latter is of particular significance since it interprets and summarises the others, giving a general outline of the suicide prevention procedure that prison staff are expected to follow.

18. Its opening paragraphs emphasise the importance of obtaining information on prisoners' circumstances and characteristics and of ensuring that this is passed on to the prison doctor "who must necessarily take the lead in suicide prevention measures". Three types of information are distinguished: that from outside sources such as the police, the probation service, doctors and the prisoner's family; that obtained by talking with and observing the prisoner himself; and if the prisoner has been imprisoned previously, that contained in previous records.

19. The circular further recommended that inmates should be treated sympathetically that "they feel they can talk about their problems when they are most pressing". This w often be when the inmates are received into custody, hence the importance of probati officers, chaplains and prison doctors seeing them soon after arrival. There are furth criteria to assist staff to identify those at serious risk of suicide who have not been identifi previously. Prison doctors and hospital officers had most exposure to those events, follow by Governors and Discipline Officers; chaplains' involvement tended to be restricted what happened after death and probation officers remained more or less on the sideline

20. It was noted that a full-time rather than a part-time doctor was required to meet t demand. On occasion there was a shortage of hospital accommodation. Providing intensi surveillance has obvious manpower implications, especially in local or remand establis ments. This applies to attempting to control self injury as well as suicide.

21. The report recommends that the main responsibility for individual preventi should be undertaken by Prison Medical Officers. While the referral process should known and clear, there should be close co-operation between the prison doctor, chapla and probation officers in working with these prisoners. Outside probation staff may need be reminded that they should bring information about possible suicides to the attention prison authorities, even though they may have already recorded this information within Social Inquiry Report. We support the recommendations wholeheartedly and encoura their implementation. We recognise the resource implications, especially in overcrowd local prisons and recommend an urgent review of staffing needs in prison medic departments to ensure that they are given the priority they require.

22. The doctor is responsible for assessing inmates before they undergo disciplina hearings. He should assess the suicide potential of any inmate being discharged, either court or another prison and advise staff dealing with the prisoner accordingly. A form f the purpose can be attached to the papers. Our experience suggests that this should app particularly to remand prisoners' appearance at court, not only in respect of suicide but ar other medical condition which may develop under the stress of the court appearance ar sentence eg a remand prisoner on a murder charge suffered a stroke in prison and it w known he had undergone cardiac surgery the previous year. When sentenced, he collaps in the dock. Prison officers had to administer first aid until an ambulance arrived. Despi the medical history and a reasonable expectation that he might experience stress durir and at the close of the trial, no arrangements were made by the prison medical authoriti for medical attention to be at hand. We believe there is a need for medical through-care much as social work through-care. This needs greater attention.

23. Probation staff reading parole dossiers on prisoners serving medium to long-ter sentences for the Parole Board, note that in a few but significant number of cases whe prisoners have been considered for re-categorisation from Category B to Category C transfer has been prevented because the prisoner requires a full time medical officer, whic is not usually available at lower category establishments. This situation can be experience as critical by the person concerned in respect of his early release on licence. We believe th this position need not arise if there was provision of the necessary medical cover from th local health authorities under the National Health Service.

24. While part-time medical officers have been experienced negatively in som establishments, it has been reported that Bullwood Hall has visiting local Gener Practitioners who provide an excellent service. One of the beneficial consequences linking into a Group Practice is that decisions relating to whether or not an inmate shoul be admitted to an outside National Health Service hospital, are made on the same criteri as in the general community. It is, however, necessary for one designated doctor in th group to be identified with this specialist area of work to be willing to participate in pos graduate forensic training and to be up-dated periodically.

Summary of Recommendations

1. We recommend that only medical officers with psychiatric qualifications should writ psychiatric reports.

2. We recommend that a regional forensic psychiatrist should be appointed on a joint asis.

3. We recommend that the quality and selection of medical staff should be enhanced by he incentive of forensic specialist status.

4. We recommend that prison medical officers should be part of and accountable to the lational Health Service.

5. We recommend that all hospital officers should be trained to obtain at least SEN.

6. More time and resources are required by the Prison Medical Department, especially n local and remand prisons. This needs priority attention.

7. There should be a continuous monitoring of each establishment's use of drugs and edative medicines.

8. We recommend that the prison medical officer's relationship vis-a-vis the Governor nould be reviewed. It should be more in line with the joint accountability of the Education)fficer or probation service.

9. We recommend that liaison with specialist outside facilities and personnel be sought n respect of drug addiction and drink related programmes. These should be built into co-rdinated resettlement planning.

10. Prison medical staff need to co-operate with and co-ordinate the knowledge and kills of the chaplain, Education Officer and probation staff in working with particular ersons, eg suicide risks, the mentally sick, the handicapped and chronically ill.

11. Doctors need to develop medical through-care practices parallel to the social work nrough-care model.

12. Medical decisions and treatment within institutions should be based on the same riteria as those within the general community.

Memorandum submitted by the National Association of Probation Officers

1. The National Association of Probation Officers welcomes the opportunity to submit vidence to the Social Services Committee on the Prison Medical Service.

2. The Association believes that there are weaknesses in the prison medical service vhich need to be addressed. In the course of this paper we highlight the issues we see as eing of prime importance.

LACK OF ACCOUNTABILITY

3. Under the 1948 National Health Act, everyone has a right to choose his or her own octor. If NHS patients are dissatisfied with their treatment they have various avenues of omplaint—to district and regional health authorities, family practitioner committees, ommunity health councils and the health ombudsman.

4. In contrast, a prisoner has no choice as to his or her doctor—under Prison Rules 1964, ule 17 states that "the medical officer of a prison shall have the care of health, mental and hysical, of the prisoner"—and none of the NHS avenues of complaint have any standing n relation to the prison medical service.

5. The Home Office point to several safeguards prisoners have for the quality of t medical treatment they receive. The Home Secretary is accountable to Parliament for t provision of medical services in establishments; prisoners may petition the Home Secreta and put complaints to the governor and the board of visitors; the service is subject to system of supervision by management and, following the May enquiry into the pris service, the prison inspectorate includes a doctor. The trouble is that of these the nearest outside, independent scrutiny is the prison inspectorate and one part-time medi inspector for about 120 establishments is not many. Also, the governor and the board visitors do not have the medical expertise to question medical treatment.

6. Prisoners' inability to freely seek a second opinion and to have to refer complain through prison channels causes cynicism and mistrust in the institution's medical faciliti Many inmates believe that they are receiving an inferior medical service whether this is fact true or not.

Strained Loyalties

7. Part of the cynicism and mistrust is based on a recognition by inmates that t demands and interests of "good order and discipline" in prisons frequently conflict with individual prisoner's interest and health. An example is in disciplinary procedures since t very process of punishment often deprives the prisoner of his/her rights to conditio favourable to his/her health.

8. It is not always clear to the prisoner when the doctor is acting in his/her interest when in the interest of the institution. It is not made clear that a doctor could have a confli of loyalties and that information about an individual prisoner's health which would strictly confidential on the outside is available to the governor and other members of t staff and can be used in making decisions about the conditions under which a person held. Working within the restraints of the institution it may be difficult for the prison doct to act in all respects in the interests of his/her patient, the prisoner.

Institutionalisation

9. A prison medical officer is vulnerable to the process of institutionalisation. The Roy College of Psychiatry is quoted in its submission to the May Committee on Prison Refor as suggesting that the lack of opportunity to practice outside the prison and the conflict loyalties in trying to act in both the patients' and prison authorities' best interests, can on have a deleterious effect upon professional performance and makes the servi unattractive, especially to those well qualified to obtain posts elsewhere.

Prison Hospital Officers

10. Medical officers are assisted by hospital officers who are prison officers with rudimentary nursing training. According to standing orders, the hospital officer in charge responsible for the maintenance of proper order in the hospital and for ensuring that t instructions of the governor and medical officers are carried out.

11. Hospital officers are expected to carry out a wide range of duties within priso hospitals, despite receiving only 24 weeks introductory training; and until 1983 it was onl 13 weeks. In the NHS a state enrolled nurse has two years' training and a state registere nurse has three years. Of the 8–900 hospital officers, some 10 per cent happen to h qualified nurses but this is by coincidence rather than overall plan; although in 198 recruitment campaigns were mounted to improve the ratio. There is no regular or forma system by which hospital officers can be seconded for statutory nursing training.

12. Both the Prison Officers' Association and the Royal College of Nursing argue th training of hospital officers is inadequate and the College of Radiographers have for som years expressed their concern that radiography was being undertaken in prisons by priso officers who do not possess the necessary training and qualifications which are statutor

equirements in the National Health Service. The overall situation was summarised by Dr enjamin Lee, formerly a member of the Prisons Inspectorate, writing in the Lancet in 983:

"There was no doubt in my mind that some hospital officers did take on, or were entrusted with, medical responsibilities far greater than was warranted by their training, knowledge, experience or attitude."

ECRECY

13. All prison doctors sign the Official Secrets Act and the papers they write are subject o Home Office scrutiny before publication. When prison doctors have attempted to omment on prison conditions their remarks have been suppressed or, worse, they have een sacked. Not surprisingly the prison medical service has been notable for its silence on ie issues and controversies of both the prison system itself and their own service.

14. The secrecy of the prison medical service extends to a lack of openness of debate on ie difficult ethical and social problems in their work. The "Prison Medical Journal" chieved only 23 issues and there has been a Prison Medical Association only since 1983. In ie past meetings of prison doctors have been banned to the press and other outsiders lest iey should "inhibit discussion". The isolation of the prison medical service within iedicine and of the individual prison doctor within the service could contribute to this lack f openness.

15. An inevitable consequence of the secrecy which surrounds the prison medical service the difficulty of obtaining evidence of its operation and details of case histories. Members f our Association who work in prison probation departments are also subject to the)fficial Secrets Act. The situation of our members in the field is similar to that of the eform groups who are outsiders looking in and lacking first hand experience of the practice f the prison medical service; although probation officers do get accounts from clients who re, or have been prisoners.

'HE QUALITY OF THE PRISON MEDICAL SERVICE

16. Concern about the prison medical service often focuses on the relatively rare ensational cases involving the death of a prisoner and on the use of drugs in prison. Although these cases raise serious issues, attention must also be paid to the everyday xperience of a poor quality medical service offered to prisoners. It is this kind of xperience which is more wide-spread amongst our members and gives rise to much of our oncern. Prisoners often find it difficult to see a doctor because they are screened by prison fficers at the first stage. Often prisoners complain that when they see the doctor, he or she akes the attitude that the prisoner is "trying it on" and examinations are cursory. ometimes prisoners are treated with aspirin and it is only when trouble persists that eference to outside facilities brings real medical problems to light. Prisoners under rescription or treatment on entering prison have had this discontinued or amended, with etrimental effects. Prisoners have been unable to get letters supporting supplementary enefit claims and in one case a request for medical records to pursue a compensation claim vas refused by the Home Office. Complaints of this type are common and, although not ensational, deserve to be taken seriously.

17. Another area of concern is the quality of medical reports prepared for courts when sychiatric assessment has been sought. Reports are often peremptory or sometimes mainly epeat social background or enquiry already available to the court. Some reports—particu- arly those concerning fitness to plead—show no understanding of the court's needs and an lead to unhelpful delay. Sometimes people clearly in need of psychiatric treatment are ent to court with reports which make no medical recommendations. These reports ontribute to concern about the standard of care for disturbed persons in our prisons.

18. Prisoners' rights groups have put forward arguments and evidence on the eficiencies of the prison medical service over the years and the personal account of ndividual prisoners have been notable, eg John Stonehouse was convinced, following his

heart attack whilst in Wormwood Scrubs, that to keep men in the hospital there "is m than punishment, more than cruelty, it is medical murder" (Guardian 17.11.78).

Deaths in Prisons

19. Public disquiet has centred around the high suicide rate in prisons and arou individual cases in which care appears to have been inadequate. Various reports h provided evidence of these cases, as in "Deaths in Prison" written by Roger Geary a published by the NCCL (October 1980) and "The Death of Richard 'Cartoon' Campbe the report of the public enquiry led by Tom Cox MP and convened by the Battersea a Wandsworth Trades Council (November 1980).

20. Suicide rates tend also to be high in prisons in other countries but some systems h reduced their suicide rate, as in Michigan, which suggests this is not inevitable. The inqu verdict of "lack of care" in the case of Mr Heather-Hayes has led to a review of suic precautions by the Inspectorate.

21. Public worries and concerns are probably heightened by the suggestion that pris doctors, through their institutionalisation, might be more likely to cover up abuses.

Drugs

22. The controversy in recent years has been the Home Office denial that drugs are us as instruments of control as distinct from treatment. It is not easy to obtain full a concrete evidence but the indications do point to the use of drugs for control rather th treatment.

23. Prison statistics show prisons with similar populations having different patterns drug usage and the amount of drugs prescribed in prisons overall has reduced over the l two/three years against a background of complaints and concerns regarding the use drugs in prison. In the same time there has been an increase in the use of physical restrai and the employment of "strip cells". The study "Treatment of Psychopaths with Depixo produced by a former prison medical officer, Dr C H McCleery (Prison Medical Journ October 1978) describes how prisoners who are identified as a control problem becor "medical" problems in need of treatment.

24. At the very least, it can be concluded that drugs are used for control purposes some occasions and in some prisons, particularly women's prisons. NAPO is deep concerned at this abuse of medical treatment which can be imposed without the authori or consent of the patient.

Integration of the Prison Medical Service within the National Health Service

25. NAPO takes the view that the prison medical service should be dismantled and th medical facilities for all penal institutions should be provided by the NHS. It is n suggested that all the short-comings of the health provisions for prisoners will thereby l solved but there are strong advantages to be gained by integration.

26. There is considerable evidence that the present system does not have the confiden of inmates: integration would go some way to gaining that confidence. Public confiden will be increased as separation from the prison department will lessen the suspicions of lac of care and internal cover-up of abuses.

27. The quality of the service to inmates will be improved in several respects. Poo recruitment and training, professional isolation, institutionalisation, lack of accountabili and strained loyalties have all been identified as affecting the quality of the service and i ability to act in all respects in the interests of the prisoner patient and integration wi remove or lessen many of these. Continuity of treatment will be much easier to achiev within the NHS and properly qualified nursing and radiography staff will yield obviou benefits.

28. As part of their duties, prison medical officers advise on the health and hygiene of e establishment. A useful accompanying reform to integration within the NHS would be transfer this inspection role to local authority environmental health officers. Ending rown immunity under food hygiene and health and safety legislation would further give e backing of legal sanctions to inspections. The Prison Medical Association has already id that the Home Office should "open its door to local authority community physicians or ıvironmental health officers or appoint such officers of its own to ensure that the hygiene prison establishments falls into line with other buildings which are not Crown property."

Examination of Witnesses

Miss P I Barrett, Chairman, Throughcare Committee, and Mr G P McNeal, Member, hroughcare Committee, Association of Chief Officers of Probation; Mr Rob Thomas, hairman, NAPO Criminal Justice Committee, Mr Brian Hampson, Secretary, NAPO riminal Justice Committee and Mr Peter Bowyer, Research and Information Officer, ational Association of Probation Officers, called in and examined.

Chairman

Thank you very much for agreeing to ome and give evidence to us, and for the ocumentation you sent. My colleagues, I ink, would like to start off the questions.

Mr Favell

966. May I start with a general question? an you tell us a little bit about the role of robation officers in the prison service?

*(*Miss *Barrett.)* Certainly. The probation ervice has seconded probation officers in ie prisons who are concerned with the ocial work needs of prisoners, both in elation to their life within the institution nd with particular concern for their dis-harge and through care arrangements with ie field officers outside. They are part of a eam of specialists and work in a number of stitutions with shared work with uni-ormed staff. But they have knowledge and xperience which can provide specialist ssistance to the regime and resourcing of ie institution, and to assist the prisoners in eir daily problems as they arise, particu-rly with families.

967. Do you agree with that?

*(*Mr *Thomas.)* Yes, indeed. That seems to e a fair summary of the facts of our job. erhaps I could say a little about the ustrations of that job. Many of our mem-ers are constantly feeding through us their oncerns about not being able to carry on ie kind of work they were able to carry on the outside community because of the ustrations of the institution and the line of accountability which in fact runs across what is seen to be good, ethical, social work. So that is one thing that NAPO is very strongly concerned about. While we have got to offer that to prisoners, we feel we are not allowed to offer it at the moment.

968. Are you saying that you are denied access to prisoners when you wish access to prisoners or this is some conflict merely just between the two of you?

*(*Mr *Thomas.)* Occasionally, because of staffing problems in the prisons, which you have perhaps heard about from the POA, we are denied access simply because there are not enough prison officers to arrange for visits by probation officers and sometimes even prison officers to accompany probation officers working in the prisons from one part of the prison to another. But, it is not just that, there is also the question of issues such as security which do hamper the role of the probation officer inside the prison. It does not make the probation officer as effective as he or she would like to be.

Mr Winterton

969. Are you denying that security in prison is important?

*(*Mr *Thomas.)* Of course not for one minute.

970. Would you clarify exactly what you have said to my colleague Tony Favell because you have said security impedes and restricts and inhibits the movement of probation officers. How could security be

[Mr Winterton *Contd.*]

improved to remove that security which the public outside feel is inevitable and must be there?

*(*Mr *Thomas.)* I am not for one minute suggesting NAPO wishes to remove any of the aspects of security that pertain in prisons at the moment. What I am suggesting is because, in our view, of the lack of resources that exist in prisons, there would be for instance the lack of sufficient visiting rooms for probation officers which can be checked in advance and, therefore, made secure and we do not, therefore, have the access we would like to have. That is one issue. A separate issue is the fact that occasionally because probation officers are subject to the Official Secrets Act, if they are working in a prison, that makes it difficult to communicate perhaps with outside organisations in as free a way as they would like.

Mr Favell

971. What amendments would you suggest to the Official Secrets Act to enable you to do that?

*(*Mr *Thomas.)* Our Association has not got a policy on that but I think it is sufficient to say that our members are very uneasy about being restricted by the Official Secrets Act and would like a review of that procedure.

Mr Winterton

972. Which organisation would you like to communicate with from which you are barred at the moment because of the Official Secrets Act?

*(*Mr *Thomas.)* It is our understanding of that position that if a prisoner makes a complaint to us then we are not always at liberty to talk about the full details of that complaint outside of the institution.

973. There is the Board of Visitors, is there not?

*(*Mr *Thomas.)* Indeed.

974. Why not register it with them? You could do that, that is not against the Official Secrets Act.

*(*Mr *Thomas.)* The Board of Visitors that exists at the moment in NAPO's view struggles hard and valiantly to do a job of work but that very body itself does seem to be hampered by similar problems we face.

975. Why not suggest the prisoner writes to his Member of Parliament or her Member of Parliament?

*(*Mr *Thomas.)* It is becoming someth of a monologue.

976. You are making it a monolog Your Association has no particular view policy on it yet you have made a statem which I think needs clarification.

*(*Mr *Thomas.)* Which particular st ment?

977. You are saying you are restricted the work you do because of the effect of Official Secrets Act. You have in no w justified the allegation you have made.

*(*Mr *Thomas.)* I have attempted to just it by explaining that our members prisons do not feel as free as they wo wish, to talk about the kind of proble that they face inside prisons.

978. That was not exactly what you sa You said you could not follow up wh complaints were made by those prison with whom you were in contact when th had a complaint to make. I said what abo the Board of Visitors, you answered it in inadequate way. I said what about t Member of Parliament, again you ma little or no comment. I am saying has t Association any policy or stated position this?

*(*Mr *Thomas.)* Our Association has policy in that area, it is correct.

979. If it is so serious why have they n got a position on it?

*(*Mr *Thomas.)* We have not been asked draw evidence on that point. There is huge amount of work that our Associatio undertakes. It is an area of work at t moment that we have just not had time expand on.

980. May I suggest you do and do n make allegations in front of a Committ like this unless you can justify it.

*(*Mr *McNeal.)* I think one of the frustr tions inevitably is the needs of the instit tion come before the needs of the prison that means as far as a probation officer concerned, seconded to a prison, very ofte finds all kinds of frustrations working that prison that he or she will not exper ence outside. When my colleague tal about some of the frustrations being exper enced I think they are readily acknow ledged by those who work within th institution.

Mr Winterton *Contd.*]

(Miss Barrett.) May I add to that? Quite cently over the last two years members of ie Association of Chief Officers of Proba- on have been involved in a working party ith representatives of the prison depart- ient, prison governors and with C6 and robation inspectorate in the preparation of document entitled Report of the Working roup on the Review of the Role of the robation Service in Adult Penal Establish- ients. That has just been published on ecember 13th and it has sponsored two ieces of research looking at social work eeds of prisoners and looking at the work urrently being undertaken in institutions, dult institutions, and looking forward to ie greater development of sharing work etween the professional specialists within enal institutions and the uniformed staff. hat document I think would indicate the hanging roles that are being undertaken in number of institutions at the moment hich emphasises particularly our consulta- ve role and the way in which some stablishments are beginning to develop ieir regimes, particularly where sentencing two years or less, towards resettlement rogrammes. I think that we have an active art to play in that particular role.

Chairman

981. Miss Barrett, would it be possible or you to let us see that document?

(Miss Barrett.) Willingly, it is currently ublished by the prison department.

982. It is available?

(Miss Barrett.) It is available and all the esearch is available.

Mr Favell

983. Do you experience any broad frus- rations in contact with prisoners who are in ospitals or hospital wings or is it just a eneral feeling you have?

(Miss Barrett.) From our Association's oint of view the probation staff who are inked to hospital wings where they exist in arge prisons, particularly Parkhurst, Wandsworth and Grendon, which have the arge hospital wings, are usually the social vorkers to that ward; in effect there is no roblem in that sense.

Mr Patchett

984. ACOP suggests that prison medical fficers, in contrast to psychiatrists in the ommunity, rarely consult with probation fficers when preparing court reports. NAPO says that medical reports are often peremptory and sometimes merely repeat information available to the court in the Social Inquiry Report. How can the situation be improved?

(Miss Barrett.) By better communication between the two groups, the Prison Medical Service and ourselves. We do have a lot of communication with psychiatrists and there is an understanding role between probation staff and psychiatrists; whether it is the volume of work and pressure of time in some local prisons which makes it more difficult, it does seem that there is less communication between the two and that when probation staff have tried to communicate some medical officers are not readily available.

Chairman

985. How have you tried to remedy that situation?

(Miss Barrett.) I think it has been a rather piecemeal approach.

986. By your organisation?

(Miss Barrett.) Yes.

987. Without response from the other side? Is that what you are saying?

(Miss Barrett.) Individual probation staff working with individual prison medical officers have tried. It is not something which the Association has tried to take up with a group as such.

988. Would it not be a good idea, if you feel that communications are not good enough, to have a word and see if they could be improved?

(Miss Barrett.) I think this does happen between individual probation areas and local prisons. I think the fact of the matter is that over the years because of increases in the workload the extent of telephone conversations and contacts have been reduced. That is very, very regrettable. But local contact is certainly made. The problem is always being aired. We are in fact in consultation. We have an appointment arranged to see Dr Kilgour over drug issues shortly. I am hoping that that may open up a channel of communication in which we can debate other matters, too.

989. It will give an opportunity to raise these issues, will it not?

(Miss Barrett.) That is right.

990. Would you wish to see all psychia-

[Chairman *Contd.*]

tric reports done by a psychiatrist outside the prison?

*(*Miss *Barrett.)* We do not really mind. The question of whether somebody is remanded in custody or not should not depend on the need for a psychiatric report but on other issues. Certainly with the forensic psychiatrists where they exist there has been a greater freedom for reports to be prepared by them either outside or inside the institution. That matters little. I think the important thing is that the person undertaking the report has the qualifications and knowledge and experience to do so.

991. Yes. Last year we did take evidence from both your organisations when we were looking at the problems of the misuse of drugs, as you probably remember.

*(*Miss *Barrett.)* That is so.

992. You mention a scheme to help drug abusers at Stoke Heath youth custody centre. Can you tell us about this and any other new developments concerning drug or alcohol abuse within the prisons, because we have come across in our visits a good deal of information about the whole question of drug abuse, of prisoners coming in, and that sort of thing. I wondered what progress you have had?

*(*Miss *Barrett.)* I cannot add much. We have recently been undertaking a survey of available information about the communications between our two services, that is the medical services and probation service, concerning drugs and drug abuse problems, as a precursor to our discussion with Dr Kilgour and other representatives. It is hoped that from that information we will gain more knowledge of schemes which might be integrated into the prisons in the same way as the Staffordshire experiment which seemed to go very well from the information we had.

993. Mr Bowyer, I believe that you also gave evidence to us?

*(*Mr *Bowyer.)* Yes.

994. Would you wish to add anything to that?

*(*Mr *Bowyer.)* Not in terms of any knowledge of the spread of the problem. In relation to your earlier question I cannot add much more to that. But in our evidence we did point out some disquiet over treatment of addicts who are received into prison. Certainly the scheme that the Association of chief officers have drawn atte tion to was very welcome. I think that w mentioned when they gave evidence the la time, if I remember rightly. But we wou see that as a good example of what wou come out of full co-operation, continui improvement of treatment, particula doctors working within the prison servi being exposed with other colleagues to t latest developments in treatment and wa of handling these problems.

*(*Mr *Hampson.)* I think there is also t element that the POA have addressed; th is the question of resources and staffin There are and have been a number schemes which have been attempted in number of penal establishments throughou the country but lack of finance and lack staff has meant that a number of tho unfortunately have had to close. I think th was one of the things that Mr Thomas w referring to when he was talking about th frustrations of the service. There is a lot work that we believe could be done i institutions but the POA do not have th staff to unlock men; they do not have th staff to escort them to wherever the meetin is supposed to be. It is not possible undertake the work that at times we woul like to undertake.

Mr Winterton

995. Have you got any examples?

*(*Mr *Hampson.)* I can give you a ver quick example of a prison close to where live, a Category C prison.

996. Name it.

*(*Mr *Hampson.)* Haverigg, where there i a shared social work scheme. Because of th new restrictions on finance where the indi vidual governors have got to account fo their own prison—I do not know what th term is—that had to be closed immediatel because they did not have the mone available for staff training, which was hov the staff were put onto the shared socia work scheme. I cannot give you any mor examples here and now, but certainly we d have examples at NAPO headquarters tha we are quite prepared to forward to you.

997. Could you do that? We would b very grateful I am sure.

*(*Mr *Hampson.)* Yes, of course.

*(*Mr *Thomas.)* If I could chip in with an example of my own. In the local prison ir which I work in Cardiff there was a visiting block built in the 1970s to improve the visiting facilities both for solicitors anc

Mr Winterton *Contd.*]

obation officers and other persons and milies of prisoners. That visiting block as never turned over for that purpose. We e still using the same building, a very little it in the main prison complex, that was ed in the 1970s. So clearly it is very fficult to book visits in Cardiff prison in lvance; you sometimes have to wait longer an you would wish.

998. Your Association's paper—and I fer particularly to paragraph 7—states at where a regional forensic psychiatrist as been appointed the quality of service to e remand prisoner and liaison with the obation service has improved markedly. an you give an example of where this has ppened?

(Miss *Barrett.)* Yes. Malcolm Faulk was ppointed forensic psychiatrist in Hamp- ire to the West Regional Hospital Board any years ago now, and has done some cellent work there. Dr Bluglass is well nown in the Birmingham area; I think ere are two in Liverpool, Merseyside; and y comments from those areas comment on e speed and the openness in which reports n be achieved. Communication has im- oved. There is a greater awareness of the oblems which face both remand prisoners id men in prison. Certainly there has been greater investment in establishing interim cure units, which were very necessary and hich in some areas have been very slow to t off the ground. In fact, there is at least ie area to my knowledge which still does ot have one; and they are very necessary. o those are the sorts of examples we would ave in mind.

999. As a supplementary to that last mark that you made, are there enough aces in interim secure units?

(Miss *Barrett.)* The majority of them have ot been fully established yet. I know in my vn region, which is the north-west London gion, we have got an interim secure unit 15 beds established at Ealing Hospital ere Dr Dolan is responsible. We are lighted to have him with us at last. But ere are two proposed smaller units to be tablished in the area, one for mentally fficient persons and another for mentally sturbed, neither of which has yet been tablished.

1000. Do you feel that the envisaged, as were, places in these interim secure units e going to be sufficient and perhaps I ght direct that to your colleague organi- ion NAPO?

(Miss *Barrett.)* Originally my personal guess was that they would be insufficient but I have been advised that the knowledge of drugs that can now be used has improved so rapidly that it may be possible that people do not need to stay in interim secure units as long as I had envisaged in my limited knowledge.

(Mr *Thomas.)* We have not had any complaints from members on this particular subject, I am afraid I cannot help you with that.

1001. As a supplementary to the first question I put to you: would you welcome then working with prison medical officers if they could undertake outpatient work with offenders who are not remanded in custody?

(Miss *Barrett.)* It makes no odds, providing they have a qualification to undertake the work and that they are accessible. From my Association's point of view we have no strong views.

(Mr *Thomas.)* Yes, I would agree with that.

1002. Miss Barrett, your Association says that a significant number of prisoners have been turned down for transfer to a Category C prison because they need a full-time medical officer?

(Miss *Barrett.)* Yes.

1003. Can you tell us more about this from the experience of yourself and the Association?

(Miss *Barrett.)* This came particularly from representatives of the Association who had served on Parole Boards and was based on that experience where any description of persons who had been considered for re-categorisation from one category to a reduced category as part of the career process for their ultimate discharge and being given a due date for release while they might have been otherwise suitable to go, for example, to an open prison for the last six months of their period in custody, because of a medical problem it was deemed on more than one occasion that this was inappropriate because of the lack of medical resources that were provided in that particular institution. I think if the resources had been readily available through the normal National Health Service rather than through the particular prison service response then this problem need not have arisen.

1004. Would you put forward any imme-

[Chairman *Contd.*]

diate solution to the problem? You have said if it was available through the NHS it would not have arisen, there are clearly ways through the existing structure that it could have been overcome.

*(*Miss *Barrett.)* I would have thought so which was one of the reasons why I was surprised by the evidence given to us but there was sufficient experience to feel it was justified.

1005. But the number or cases to which you refer, I assume, are fairly limited?

*(*Miss *Barrett.)* That is true.

*(*Mr *Hampson.)* Perhaps I might add something to that, again referring back to Haverigg Prison, Category C, on the coast of Cumbria, they will not transfer men to Haverigg who suffer from epilepsy because Haverigg does not have a full-time medical officer. There is no nursing officer available at night and it is felt that should a man have a fit in a territory where there is no supervision then that would be unfortunate to say the least. So, it is a straight forward policy that men with that type of illness will not be transferred to that establishment.

1006. Have you any solution to that particular problem?

*(*Mr *Hampson.)* Well without talking about resources, no I cannot think of a solution off the top of my head. I think there are understandable reasons for it: it might be socially difficult for that particular person but in reality, there is moving machinery at Haverigg, somebody with an epileptic fit might fall into the machinery. I think there are good sound reasons. I would not like to argue for or against it.

Mr Favell

1007. The most disturbing thing was the fact that prison doctors had been sacked for commenting on prison conditions, that is in your paragraph 13 of your paper.

*(*Mr *Bowyer.)* That is referring to an article in the British Medical Journal 1984.

1008. Could you give us the exact reference?

*(*Mr *Bowyer.)* British Medical Journal 1984 page 288.

Mr Winterton: Comes back really to our earlier question about the Official Secrets Act.

Mr Favell

1009. Do they give examples? I have not got the British Medical Journal here. Ob ously that is a very serious allegation a something which this Committee wo want to investigate?

*(*Mr *Bowyer.)* Yes, it is nothing I can g you much more detail about.

1010. You have not got any prec details?

*(*Mr *Bowyer.)* No, it is a reference.

1011. Or names?

*(*Mr *Bowyer.)* No.

Mr Winterton

1012. Are you able to give us a referen because this does appear in your pa graph?

*(*Mr *Bowyer.)* I have just given a ref ence.

Mr Favell

1013. There is nothing you want to a to that except that it is in the Brit Medical Journal?

*(*Mr *Bowyer.)* It explains the problems

1014. It is a very serious allegation.

*(*Mr *Bowyer.)* And explaining why t Prison Medical Service might have be less forthcoming than it might have be and the general silence that surroun prisons.

Chairman: Certainly it has not be raised with us on any of our visits. We w get the article and have a look at it.

Mr Favell

1015. Have you any examples of pris officers themselves being sacked or ju prison medical officers?

*(*Mr *Bowyer.)* I have not come across a examples.

Mr Winterton

1016. This Prison Medical Journal on achieved 23 issues, is that because it h gone out of business or what?

*(*Mr *Bowyer.)* I am not sure what t reasons were.

Chairman: We have got that sorted ou Mr Winterton, we will get the cutting fro the journal.

Mr Winterton

1017. They say it has only achieved issues which I presume means for son reason it does not come out that often?

[Ir Winterton *Contd.*]

*(*Mr *Bowyer.)* It just ceased publication.
*(*Mr *McNeal.)* They were not able to find new editor.
Mr Winterton: That is the reason we ould like to know.

Sir David Price

1018. Could I address that question to APO, in paragraph 16 near to the bottom u refer to instances where prisoners have en unable to get letters supporting sup- ementary benefit claims and one case ere the Home Office refused access to edical records to pursue a compensation im; can you tell us more about those ses? Are they entirely isolated, is this ical?
*(*Mr *Bowyer.)* The case of the request the DHSS problem was just an count given by one of our members a client of his. The problem was in ation to a weight change in respect of plying for a single payment for clothes release from prison and because he s told he was not ill he could not see a ctor. With the NHS GP it is necessary get a claim form in respect of such nefits. He was told that the inmate had en a doctor for this purpose who refused help him with his request. That is one rson.

1019. As far as you know that is a one off case, you have not had any evidence given to you?
*(*Mr *Bowyer.)* No.

Chairman

1020. Did you follow up that case at all? Do you know what the end result was, was it corroborated?
*(*Mr *Bowyer.)* This came about because we were trying to collect some specific examples in our submission. This came in this form to NAPO head office. I would not know the final outcome of what happened.

1021. You do not know how it has progressed?
*(*Mr *Bowyer.)* No.
*(*Mr *Thomas.)* It is possible that quite often when prisoners or ex-prisoners give us information or relate facts to us they ask us not to take it any further, so we may not have been allowed to proceed with it any further. He may have just related the facts and said "I want the matter left there".

1022. It seems rather curious, does it not?
*(*Mr *Thomas.)* Yes.
Chairman: That concludes our questions. Thank you very much indeed for your help; we are very grateful to you.

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HOUSE OF COMMONS

SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

Wednesday 12 March 1986

Institution of Professional Civil Servants

Mr A Cooper, Miss J Winters, Dr R E Garwood and Mr Bland

Association of Members of Boards of Visitors

Mrs R Wainwright, Dr D Morgan and Mrs S Hartog

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Members present:

Mrs Renée Short, in the Chair

Mr Roy Galley
Mr Charles Kennedy
Sir David Price
Mr Nicholas Winterton
Mr Tim Yeo

Memorandum submitted by the Institution of Professional Civil Servants

1. INTRODUCTION

1.1 The Institution of Professional Civil Servants is the trade union which represe technologists, scientists and other professional and specialist staff in government and in public sector. The IPCS includes in its membership medical staff throughout the Ci Service, for whom it has negotiating rights as well as other health care professionals such dentists, pharmacists and nursing staff. This paper has been prepared in close consultat with our members in the Prison Medical Service and other Civil Service health ca professionals.

1.2 Much concern has been expressed about the general level of medical cover provid for the inmates of UK prisons. It is the view of the IPCS that the aim must be to provide t inmates of prisons with standards of medical care at least as good as that which would available to them if they were not in prison. For reasons set out in this submission, it is n always possible to do this at present and there are many improvements which can a should be made.

1.3 A number of these demand increased resources and it is our view that these shou be provided.

1.4 We consider that it is essential that the Prison Medical Service remains as independent and separately funded Service, within the Prison Service but separate from t National Health Service, with adequate resources both in terms of facilities and equipme and in terms of fully trained medical and health care staff. It should have its status a responsibilities clearly defined and its own code of practice.

1.5 We do not consider that medical provision in prisons would be improved integrating the Prison Medical Service with the National Health Service. On the contrary. is our view that if the Prison Medical Service were to have to compete for scarce funds a resources with other parts of the National Health Service, the service provided to priso would almost certainly deteriorate rather than improve.

2. THE ORGANISATION AND STRUCTURE OF THE PRISON MEDICAL SERVICE

2.1 The Committee will have established that the Prison Service is divided into fo regions, North, Midlands, South East and South West, and is ultimately controlled b Prison Department Headquarters and the Prisons Board. In addition, for most parts of th Service there is a regional management structure with its own headquarters directorate.

The cost of printing and publishing these Minutes of Evidence is estimated by Her Majesty's Statione Office at £2,916.

2.2 The structure of the Prison Medical Service complements the overall structure. dical cover is provided at each prison, although this does not necessarily mean that there medical officers employed by the Prison Service at each prison; some are covered irely by sessional doctors. The Directorate of Medical Services is located at adquarters; the Deputy Director and the three Principal Medical Officers also based at adquarters each have responsibility for a region.

2.3 In theory, prison medical staff are responsible to the Directorate of Medical Services. eir annual reports are completed by more senior medical staff, and professional matters also referred to more senior medical staff, where appropriate. In practice, since the son governors have responsibility for running their own prisons, the lines of ponsibility are rather less clear. Prison Governors do make a contribution to the annual orts of their medical staff. The Home Office has now proposed that each Prison vernor should become equal first reporting officer with a member of the prison medical vice, reporting on non-medical aspects of the performance of the doctors working in the son. The IPCS considers that this proposal undermines the professional independence of dical staff and is resisting it. The increasing pressures caused by overcrowding, and the rease in workload that this has caused, mean that medical staff may be expected to ept or make decisions which benefit the institution rather than the individual.

2.4 It is our view that it is essential that the Prison Medical Service, both in principle and practice, is independent from the disciplinary side of prison organisation.

2.5 We would also recommend that the role and responsibilities of the Prison Medical vice be more clearly defined. Any such definition should include a code of practice for medical treatment of inmates.

Pay and Grading Structure

3.1 We consider it to be essential that the pay and grading levels of the Prison Medical vice compare sufficiently favourably with those of the National Health Service to attract d retain good quality medical staff. This is not the case at present.

3.2 The Prison Medical Service is underpaid and undergraded at all levels. The post of rector is at Grade 3 level (salary between £31,000 and £34,000 per year from 1.3.86: See nex 1).* A Senior Consultant in the NHS with an A plus award, on the other hand, uld be earning well over £50,000 in 1985.

3.3 The grading of the Director compares unfavourably even with other senior medical sts in the Civil Service. Details are set out in Annex 2.* One example is the Head of the vil Service Medical Advisory Service, who has a medical staff of twelve, and who is at ade 1A (salary £55,000).

3.4 The relatively low level of the Director's grading has inevitably held down the ding of the other posts in the structure. In the majority of prisons the most senior dical post is at Senior Medical Officer level (salary £25,533); only five of the larger sons have a Principal Medical Officer in charge (salary £28,653 from 1.3.86). We would gue that the responsibilities of running the medical services in a medium to large size son equate with those of a consultant with a Grade B award (£38,670 in 1985).

3.5 Not only do the low rates of pay cause problems with recruitment of good quality dical staff; the relatively low grading levels at the higher levels of the Prison Medical vice means that the service as a whole does not carry the weight that it should either in Home Office, in the Civil Service medical hierarchy or in the NHS. The Director of the son Medical Service is a grade below the Director General of Prison Services (Grade 2) d the overall control and authority of the discipline as opposed to the medical side of the sons is thus institutionalised.

* Not printed.

3.6 It is our view that in order to ensure the independence and authority of the Pr Medical Services its Director must be graded at least at the same level as the pos Director General of Prison Services.

3.7 All prisons should have at least one Senior Medical Officer in post; and the majo should be run by Principal Medical Officers. All the existing PMO posts shoulc upgraded to SPMO.

4. STAFFING

(a) *Medical Staff*

4.1 Policies on sentencing, on parole and on mental health care have cause substantial increase in the prison population. Since 1966 the number of pri establishments has risen from 109 to 124, and the number of inmates (daily aver population) from 33,000 to over 47,000—an increase of over 40 per cent. In the same pe the number of medical staff has only increased from 79 to 88—an increase of 11 cent—although there is a certain amount of flexibility in the ability to "buy in" sessic help from the NHS.

4.2 Overcrowding in prisons and the additional stress this places on inmates ca higher levels of sickness. All new inmates have to be seen by a doctor on arrival whet they have transferred from another prison or have just been put in prison. All this me that the Prison Medical Service can only operate as a fire fighting service, strugg constantly to keep a potentially explosive situation under control. This does not make good medicine or good medical practice.

(b) *Nursing Staff*

4.3 In addition, trained support for medical staff hardly exists in most pris "Nursing" cover is provided by uniformed prison staff, some of whom may have had sc minimal nursing training. Very few have full nursing qualifications and there is li financial incentive for any prison officer to go and obtain them. It is now policy to rec nurses who are already qualified so that one third of the nursing staff have qualificatic We do not think this is adequate; in our view all the staff involved in nursing in all pris must be qualified.

(c) *Pharmacists*

4.4 Since 1966 there has been no increase in the number of pharmacists employed by Prison Department. The complement since that time has been:

1 head pharmacist
14 full-time pharmacists
4 part-time pharmacists (Leicester, Leeds, Rochester, Bedford)
2 sessional pharmacists
12 full-time pharmacy technicians.

There are pharmacists at Birmingham, Bristol, Brixton, Durham, Grendon, Hollow Liverpool, Manchester, Parkhurst, Pentonville, Risley, Wakefield, Wandsworth, Wor wood Scrubs. The part-time pharmacists are located at Leicester, Leeds, Rochester a Bedford. The pharmacy technicians are located at Birmingham, Durham, Grend Holloway (2 posts), Liverpool, Manchester, Parkhurst, Risley, Wakefield, Wandsworth a Wormwood Scrubs.

4.5 Each pharmacist provides supervisory cover for a number of other prisons so th every establishment has some pharmaceutical oversight. However, because there are so f pharmacists covering a number of prisons which may be geographically scattered, so have to travel long distances, and the Medical Officers in many establishments rarely ever, see a pharmacist.

4.6 Pharmacies are only open during weekdays and there is no evening or weekend er. Although it is possible to call out the pharmacist outside his or her normal working irs this rarely happens. At the weekends an "emergency drugs cupboard" is provided itaining a basic medical supply. It is of course not possible to predict demand and cover ry eventuality.

4.7 The Pharmacy Service is understaffed and it is therefore unable to give the best vice to prison inmates and the Prison Medical Service. A modest increase to 20 full-time ff would bring the Prison Pharmacy Service in line with the NHS target of one armacist per 100 beds and would allow the service to be reorganised into regions nparable to those run by the Principal Medical Officers in charge of the four regions of Prison Medical Service. The problem of out of hours and weekend cover could also be ılt with.

Prison Officers

4.8 Shortages in numbers of prison officers also create difficulties for medical staff and n interrupt the treatment available. If there are no prison officers available to bring an nate from the cell to the doctor, the inmate does not see the doctor. If there are no prison icers available to escort the inmate to a hospital appointment, the inmate does not get to hospital appointment.

Administration and Support Staff

4.9 The increased numbers of prisoners have also meant an increase in the administra- e tasks associated with prison medicine. The numbers of court reports and adjudication orts have increased, as well as the medical reports required on each entrant to the prison. the same time, clerical and administrative support is being cut back. As a result, highly ined professional staff are having to spend a disproportionate amount of time doing ıtine clerical work.

4.10 It is our view that *it is essential that the Prison Medical Service is adequately staffed. e numbers of doctors and pharmacists should be increased, and professionally qualified rsing staff should be employed in each prison.*

Facilities

5.1 In other respects as well, the facilities provided for medical purposes in some prisons seriously inadequate. Not all existing prisons have a full range of hospital facilities, hough all have some medical provision. Prison overcrowding has increased pressure on eady inadequate facilities.

5.2 Money for building improvements, maintenance and repair of health care commodation is included in the general Prison Service building and works budget. As a ult decisons such as that to convert RAF Lindholme to a prison meant that money ocated to improving health care accommodation was diverted to pay for the conversion the new prison. In our view, so long as there is no separate financial provision for health re and medical accommodation it is likely to remain low on the list of priorities.

5.3 It is our view that *clear standards should be laid down for the provision of medical ilities in prisons.* All new prisons should contain some hospital facilities, and that ailable in the older prisons should be extended and, where necessary, modernised to able adequate standards of health care to be provided. *The accommodation, resources and ipment available to prison medical staff should be comparable with that available in the alth Service.*

Medical Records

6.1 All UK citizens registered with the National Health Service should be able to assume t their medical records from birth are available to their general practititioner, however

many times they have changed their GP. Doctors caring for prison inmates, on the c hand, may have extreme difficulty in securing access to their previous medical records the system of keeping records inside the prison service is such that a doctor will prob not have access to all the medical information available within the prison when treati patient; and the medical history relating to a prisoner's time at one prison may nc transferred with a prisoner who is moved from one prison to another.

6.2 All prisoners are given a medical examination on arrival at any prison, and a medical history is taken. This, however, is kept on their prison record. If they becom the Prison Medical Officer may not have access to their record, but will note the prol and the treatment on a separate form. While the official record travels with the inmate f prison to prison, there is no system that ensures that the forms recording medical prob and treatment while in one prison go with the prisoner to another. It is also extrer difficult for medical staff to obtain medical records for prisoners relating to any prev period in prison.

6.3 Medical records of prison inmates are not subject to the normally rigo requirements of medical confidentiality.

6.4 *It is our view that the Prison Medical Service should be given the resources to set u adequate record keeping system which will provide a continuity of information at least as as that available to doctors in the NHS.*

6.5 *A code of practice should be established covering keeping medical records of priso the handling of this information and its transfer from prison to prison, to enable me confidentiality to be maintained.*

7. Training and Research

7.1 Training for doctors in the Prison Medical Service is quite inadequate. There are areas in which it should be provided: training in the special problems of prison medic and in-service training to keep doctors in the Prison Medical Service in touch v developments outside.

7.2 First, *all entrants to the Prison Medical Service should be given a formal perio training in all aspects of prison medical work.* This should include not only some speci training on the particular medical problems encountered in prisons, and the effects health of both short and long term imprisonment, but also a general introduction to Prison Service and its organisation. It should also cover the various procedures standing orders governing medical care for prisoners, and the legal provisions requirements that affect their work.

7.3 Secondly, one of the major problems in the Prison Medical Service has been isolation of medical staff working within it from developments in the rest of the med profession. This is clearly damaging to them professionally, not only in terms of tl medical knowledge and the treatment they are able to give, but also because it make very difficult for them to return to work in the NHS. This in turn discourages people fr applying to the Prison Medical Service.

7.4 It is, therefore, our view that *a system should be established which gives Prison Med Staff the opportunity to spend time working in the NHS on a regular—poss sessional—basis.*

7.5 It is undoubtedly true that prison life does produce additional stress for its inm and increased medical problems result. Prison medical staff are so stretched that they h no time to even consider preventative medical care, or do any research into medi problems relating to prisons, or into ways of improving the health of the prison populati Much research needs to be done, from an assessment of the real cost in health terms of "slopping out" system to more general studies on such things as the medical effects overcrowding. *Resources should be provided to carry out research into health issues affec prisoners.*

Resources

8.1 It is quite clear that many of the suggestions made in this paper have resource plications for the Prison Medical Service. We consider that if a satisfactory service is to provided, by whatever means, it is essential that the financial arrangements are such that e Medical Service has control over all aspects of its own expenditure. At present, the penditure comes under several different votes: medical staff come on the general staff te; equipment, medicines, etc come under a separate prison medical service vote; and any penditure on accommodation comes out of the general accommodation vote. This clearly ıds to problems of priorities, at least where improvements in accommodation are ncerned. This has been particularly apparent in the last few years when the major pansion of expenditure on new prison accommodation has meant that all expenditure on isting prison accommodation has had to be severely curtailed.

8.2 We also see the resource question as one of major importance in any consideration of ıether or not the medical service should be made part of the National Health Service. It is ır understanding that Regional Health Authorities have complete responsibility for termining how their money is spent. Unless specific funds can be earmarked within the ealth Service for the Prison Medical Service it is inevitable that, given the competition for nited funds that already exists within the Health Service, the Prison Medical Service, at ast in some Regional Health Authority areas, will be very low down on the list of iorities. The result will almost certainly be that in some areas the existing service is duced. It will also mean that there is no common standard of medical provision across the untry: it will depend on the commitment of a particular Health Authority to that aspect its work. Those who are arguing for the transfer of the Prison Medical Service to the ational Health Service do not appear to have taken this factor into account.

8.3 It is, therefore, of prime importance that the Prison Medical Service is funded parately and as a service, whatever the source of the funding. Its funding should include ı element for accommodation which is separate from the general accommodation ovision allocated to the Prison Service as a whole. It should also cover salaries and lated expenditure, such as fees for part-time medical staff. In this way it will maintain mplete independence from the discipline side of the Service. We do not consider that any nd of organisational independence would be anything other than nominal if the Service ere not given complete control over all its own financial resources and expenditure.

Future Organisation

9.1 In establishing any medical provision for prisoners there is always a fundamental roblem of whether medical or disciplinary considerations should take priority. At present, artly because it is subsidiary to the disciplinary side of the Prison Service, the Prison Iedical Service gives advice but has little real authority. It has no powers to insist in areas here it considers that the general health of prisoners may be at risk. Members of the rison Medical Service only have final authority on clinical aspects of the treatment of ıdividual prisoners and even then, in practice, other considerations such as availability of iscipline staff can affect the doctors real ability to take action.

9.2 This is clearly a totally unsatisfactory state of affairs and one that should be resolved. ı our view the only way to do this is to make the Prison Medical Service independent of ıe disciplinary side of the service with its own funding. Its responsibilities and its authority ıould be clearly set out in revised standing orders or a new code of practice. This should ve the Medical Service much more authority on matters affecting the health of prisoners ıan they have at the moment.

9.3 While we accept that there are areas in which health care in prisons could and ıould, be improved, *we do not consider that these problems would be solved by transferring ıe Prison Medical Service to the National Health Service.* On the contrary, it is our view ıat this would be very likely to result in a deterioration of health care in prisons.

9.4 Regional Health Authorities enjoy a very substantial degree of autonomy, and the overnment is committed to a policy of devolution of responsibility. There could be no rotection of funding within the NHS; and it is our view that the outcome would be an

uneven and poorly resourced provision of health care in prisons. *It is also essential, in view, that there is a professional medical and health care contribution at all level management in the Prison Service.* To be fully effective this needs to be part of it.

10. Summary of IPCS Evidence

10.1 It is our view that it is essential that the Prison Medical Service, both in princi and in practice, is independent from the disciplinary side of prison organisation (2.4).

10.2 We consider it to be essential that the pay and grading levels of the Prison Medi Service compare sufficiently favourably with those of the National Health Service to attr and retain good quality medical staff (3.1).

10.3 It is essential that the Prison Medical Service is adequately staffed. The number doctors and pharmacists should be increased and professionally qualified nursing st should be employed in each prison (4.10).

10.4 Clear standards should be laid down for the provision of medical facilities prisons. The accommodation, resources and equipment available to prison medical st should be comparable with that available in the Health Service (5.3).

10.5 It is our view that the Prison Medical Service should be given the resources to set an adequate record keeping system which will provide a continuity of information at le as good as that available to doctors in the NHS (6.4).

10.6 A code of practice should be established covering keeping medical records prisoners, the handling of this information, and its transfer from prison to prison, to enal medical confidentiality to be maintained (6.5).

10.7 All entrants to the Prison Medical Service should be given a formal period training in all aspects of prison medical work (7.2).

10.8 A system should be established which gives prison medical staff the opportunity spend time working in the NHS on a regular basis (7.4).

10.9 Resources should be provided to carry out research into health issues affecti prisoners (7.5).

10.10 It is of prime importance that the Prison Medical Service is funded separately ar as a service (8.3).

10.11 The IPCS does not consider that the problems of the Prison Medical Servi would be resolved by transferring it to the NHS (9.3).

10.12 It is essential that there is a professional medical and health care contribution at a levels of management in the Prison Service.

Examination of Witnesses

t Tony Cooper, Assistant General Secretary, Miss Janet Winters, Negotiation Officer, . R E Garwood, Medical Officers Section and Mr D Bland, Pharmacists Section; stitution of Professional Civil Servants, called in and examined.

Chairman

1023. Thank you for submitting your idence to us, we would like to put a few estions to you arising from the evidence u have submitted. How many members the IPCS are working in the Prison rvice?
(Miss *Winters.)* Thirty three medical embers, fourteen pharmacists.

1024. Are they working full-time or part-ne?
(Miss *Winters.)* All of them are full-time.

1025. Do they include nurses and phar-acy technicians as well as doctors and armacists?
(Miss *Winters.)* Not nurses but pharmacy chnicians, obviously.

1026. And some doctors and pharma-sts?
(Miss *Winters.)* Yes.

1027. You say that the Prison Medical rvice is under-paid and under-graded at l levels, have you pressed the Home Office out this?
(Mr *Cooper.)* We have pressed the Home ffice and the Treasury, and we have at the oment a pay and grading claim with the reasury, which has been going on for the st 18 months.

Mr Winterton

1028. How much?
(Mr *Cooper.)* At the moment doctors are uivalent to civil servants' grades, and we e trying to get them a full step up in the ructure.

Chairman

1029. Are you satisfied with the superan-uation arrangements for Prison Medical fficers?
(Mr *Cooper.)* No, we are not. We believe at Prison Medical Officers should have a ster accrual rate, in the same way as rison Officers do and psychologists in the ational Health Service.

1030. You complain that Prison Medical fficers have to waste time doing clerical ork because clerical and administrative support is being cut back. Can you give us details of where these cuts are occurring?
(Dr *Garwood.)* It is often necessary for a Medical Officer to personally get, for instance, a photo copy. One would have hoped this could have been done speedily and efficiently by a clerical assistant; that is just one small example. When the one typist in a department is on annual leave or attending, say, a dentist's or doctor's appointment, then one may be reduced to writing a letter or a report longhand, again wasting time that could otherwise be spent on medical matters, which cannot be done by anybody else.

1031. Any other effects of the cuts?
(Dr *Garwood.)* With regard to clerical services?

1032. Yes.
(Dr *Garwood.)* No. I think those are two examples of problems which exist throughout the Service, in each establishment.

1033. Which prison are you involved with?
(Dr *Garwood.)* Bristol.

1034. Is that the case in Bristol?
(Dr *Garwood.)* Yes, those are two examples which I have quoted directly from my own personal experience.

1035. What about your other colleague?
(Mr *Bland.)* I am a pharmacist and I can confirm, and I am sure some of our Medical Officers also have, these irritations and time-wasting exercises, for the simple reason we are not fully supported by adequate staff.

1036. Can I ask what proportion of the total Prison Medical Officers actually belong to the IPCS?
(Miss *Winters.)* Somewhere around 50 per cent, roughly.

1037. Do you recruit hard?
(Mr *Cooper.)* Somewhere around 60 per cent of the doctors in the Civil Service are members of the IPCS. The Prison Department is our lowest area of organisation and it is probably nearer 40 per cent in the Prison Service.

[Chairman *Contd.*]

1038. Do you know why that is?

*(*Mr *Cooper.)* There has been a dissatisfaction within the whole of the Medical Civil Service with the levels of pay which they get, and the fact that many doctors feel themselves to be doctors first and civil servants second. That was especially the case in the Prison Department where the doctors were more practising clinicians than they were in other parts of the Medical Civil Service. That was reflected in dissatisfaction with the IPCS which has since changed, and we are now recruiting doctors throughout the Civil Service and we have developed a first-class relationship with the BMA and we work together and have joint committees.

*(*Dr *Garwood.)* Most doctors, when they first qualify and throughout their career outside of the Prison Service, by tradition belong to the British Medical Association, and it is only when they come into the Prison Medical Service that they no longer find they belong to the body with negotiating rights. The BMA does not have negotiating rights for the Civil Service, as you are probably aware. It may be a little while before the significance of this dawns on the Civil Service Medical Officer.

Sir David Price

1039. Can you explain why in your paper you oppose the Home Office move to make Prison Governors equal first reporting officers for Medical Officers? Especially as we have it in your paper that they have been reporting on the main medical aspects of the performance of the doctors working in the prison.

*(*Dr *Garwood.)* There are inevitably areas of conflict of interest, if I may put it that way, where it may be of some irritation to the Governor when the Medical Officer insists on a particular standard of medical provision. One example is if the Medical Officer feels it is essential for the inmate to be taken to an outside hospital for emergency treatment. This requires an escort of a minimum of two Prison Officers. The present staffing situation amongst Prison Officers is such that that escort is often not available and this puts the Governor under pressure. The doctor may face a dilemma: he must, of course, put first and foremost the medical interests of his patient, and this may inevitably cause some irritation to the Governor. Under these circumstances it is invidious if the Governor shall report on the performance of that same Medical Officer.

1040. That is presumably the reason you suggest in your paper that the Pr Medical Service should be independen the disciplinary side of the prison organ tion?

*(*Dr *Garwood.)* That is correct.

1041. But what I think we found a l confusing—that, I see, flows logically that you then suggest there should b medical contribution at all levels of m agement. I cannot see how these are q compatible.

*(*Dr *Garwood.)* They are compatible the sense that in an ideal situation Governor will take advice from the Med Officer rather than instruct the Med Officer in a line management fashion.

1042. Does he not take advice now?

*(*Dr *Garwood.)* There is a tendency so times for the sort of conflict of inte which I have already described to oc Ideally it should be good management one can put it that way. The best Govern do their best to practice this, but sometim there are difficulties.

1043. Presumably they arise over matt of prison hygiene, that sort of area?

*(*Dr *Garwood.)* That is a very g example.

1044. Is it necessary then that the me cal input into management and the hea care of prisoners should be done by same people? We have had suggestio from other witnesses they could be sep ated, I do not know how you feel ab that?

*(*Dr *Garwood.)* Unless one is going duplicate one's staff, I do not see how th can be separated.

*(*Mr *Cooper.)* It is possible to separ them, could I suggest. What we wou argue is, it is not logical or efficient separate them in a group of staff who a responsible for the medical aspects, who a able and capable and should advise on t health care aspects as well.

Mr Kennedy

1045. Following on from that, you a opposed, as you say in the paper, to t integration of the Prison Medical Servi into the NHS and you cite one of your fea as being that it would lose in resource tern Given then that you want the distinctio do you think it is important that the Pris Medical Service remains a Home Offi

Mr Kennedy *Contd.*]

sponsibility or might a move to the DHSS elp to underline the separation that you ere just talking about from the disci- inary side of the service?

(Mr Cooper.) We would not like that at l. Whilst we are suggesting there should e a clearer distinction between the medi- il prison service and the disciplinary de, we do not suggest it should be in any ay divorced; they are part of the neces- ry management and organisation of the rison Service and we believe it is right at they be organised as they are now. e believe that there is certainly a lot of om for a more clear distinction between e roles of those two, but to go to the treme of separating them into different partments would create further prob- ms greater than the ones that we have at e moment.

1046. Do you think that is something at can be laid down at the centre? Is it not mething that is going to take a different rm in different situations with different rsonalities?

(Mr Cooper.) There will inevitably be fferences locally according to people's sponsibilities and dedication, but their rimary responsibility is to ensure at the ntre the Prison Medical Service is work- g to guidelines and codes of practice ntrally organised and their source of nds is allocated centrally and in their ntrol.

Mr Yeo

1047. You recommend the Prison Medi- l Service should have control over its own penditure. Can you just explain how this ould work? Would it cover, for example, spital officer staff costs?

(Mr Cooper.) Yes. I think we suggested at there is an "unco-ordination", if you e, between different provisions of re- urces. Putting aside for the minute our ew that resources as a whole are grossly adequate, there is unco-ordination with e provision of resources for different ings like staff accommodation facilities. hat could be brought together under the rison Medical Service and funded as one, that rational decisions could be made out different priorities and allocations ithin one group rather than having to ake those arguments for priorities across irly distinct boundaries between manage- ent groups which then limits the effi- ency and effectiveness of that allocation rocess.

1048. Could that not still be done if it were all within the National Health Service?

(Mr Cooper.) Anything can be done. Our view is, if it was within the NHS, first of all there would be a very great deal more difficulty in co-ordinating those different allocations. For instance, the allocation of resources on facilities and on accommodation would necessarily remain with the Prison Service. It would be extraordinarily difficult to separate those. So you would get a worse problem of allocation than you have at the moment.

1049. On another point, you suggested the decision to build new prisons had meant that funds have been directed away from health care in prisons. Would you like to enlarge on that?

(Mr Cooper.) Yes I think our point there is simply that inevitably when decisions are taken to commit fairly substantial resources to something with limited overall resources, then there is a siphoning off of resources from other places in order to do that. It is an inevitable process.

Mr Yeo: Can you quote some examples for me?

Chairman

1050. Which sort of new build are you concerned about? New build to accommodate additional prisoners coming in or do you mean new build to replace hopefully the old-century-old-prisons so many people are in?

(Mr Cooper.) The point we are making is that we were given to understand when the decision was taken to convert RAF Lincombe—it was taken at fairly short notice —some of the resources that went into that conversion were taken from the money which had been allocated to improving health care accommodation in the Prison Service as a whole.

Sir David Price

1051. Surely the general proposition, as we understand it, is that better prisons should make a contribution to better health care?

(Mr Cooper.) Indeed, and better prisons should have proper facilities built into them and existing prisons should have the facilities they have got upgraded. It is a question of overall resources.

(Dr Garwood.) If I may intervene, one may find one is at risk of getting into the

[Sir David Price *Contd.*]

situation of robbing old Peter to pay new Paul.

Chairman

1052. Poor old Peter, he is in a mess anyway.

*(*Mr *Cooper.)* We accept that there is inevitably competition for resources. We believe that the way resources are allocated at the moment means some of the decisions in the prison medical area are not necessarily rational. We take the view, however, that, for instance, in the extreme case of putting the Prison Medical Service into the National Health Service would cause worse problems of priorities. We cannot envisage, for instance, that if a local hospital ward were to close, or that was being considered, and at the same time there was need for increased resources for one or two local prisons, the prison would get those resources. Faced with the political problems of a ward closing in a hospital, we just do not believe it would happen. We are not trying to suggest a Utopia where allocation is always painless.

1053. You are realists?

*(*Mr *Cooper.)* Indeed.

Mr Yeo

1054. You said the shortage of prison officers can interrupt medical treatment of prisoners; if there is no prison officer available, the prisoner may not be able to go to an outside appointment to see a doctor. How often does that happen?

*(*Dr *Garwood.)* If I may quote one example last week at Bristol Prison we have an inmate who required urgent dental treatment at Bristol Dental Hospital. He was waiting most of the week. By the time I left on Thursday he had been joined by a second inmate requiring urgent dental treatment. I do not know what has happened since then.

1055. That is a recent illustration. In your experience, is that happening every week, every month, at Bristol?

*(*Dr *Garwood.)* Yes. There is certainly a tendency for this to be a major problem. It varies from week to week, from day to day.

1056. Do you keep a record of it so that you can monitor whether it is getting worse or better?

*(*Dr *Garwood.)* It has certainly been worse recently because dental facilities have been out of order in the prison and the situatio have just described to you about outs dental treatment has been acute for seve weeks.

1057. That is a particular crisis which not caused so much by the shortage prison officers as by the dental system?

*(*Dr *Garwood.)* It is one clear example the problem. Delays can occur when an a gets broken or a leg gets broken. It may ta time to get a prison officer into the prison order to go on the escort. The staffi situation rests on a knife-edge and it o requires, say, an inmate being an in-pati at an outside hospital which requi bedwatch, a static escort, and this c exacerbate the situation even further. O patient at an outside hospital requi approximately six staff earmarked to care alone.

Chairman

1058. You are talking about round t clock, are you?

*(*Dr *Garwood.)* Yes.

1059. Can I just clarify one point he You say in 4.8, "If there are no pris officers available to bring an inmate fr the cell to the doctor, the inmate does n see the doctor." Does the doctor not then to the cell?

*(*Dr *Garwood.)* No, because in exactly t same way as there are no staff available bring the inmate, there are no staff ava able to accompany the doctor. The doct does not go into a cell on his own.

1060. Never?

*(*Dr *Garwood.)* No, never.

Mr Galley

1061. You recommend in your paper formal period of training for Prison Medic Officers. What happens now?

*(*Dr *Garwood.)* A typical arrangeme would be that the new Prison Medic Officer is shown the general running of t prison, all departments, workshop kitchen, administrative section, for perha a period of a week. He may then sit in wi the Senior Medical Officer for perha another week or less. Then he will be aske to taken on such tasks as he is considere able to do as he is considered able to c them. That is the best arrangement that w operate. At the other end of the scale, locum medical officer being brought in

[Mr Galley *Contd.*]

sist in a staff crisis may be shown the rms which he has to complete with a few rds of guidance in general terms as to at is required, then he or she will be left do their best.

1062. So what would your proposals compass? You have given us an outline in is paper. I wondered if you could give us a w more details.

*(*Dr *Garwood.)* The sort of thing which e would be looking for would be perhaps two sections, practical guidance with an tended period of sitting in and a more adual easing into the practical duties on e one hand, going hand in hand with the ite detailed instruction on standing or- rs and rules under which the Prison edical Officer is supposed to work; there quite an extensive body of knowledge quired for that.

1063. They would need to know all that formation to do the job adequately?

*(*Dr *Garwood.)* They should have at least reasonable introduction to it, so they oid making some of the worst potential unders.

1064. Would you apply this formal train- g to part-time MOs as well as full-time?

*(*Dr *Garwood.)* Yes, because part-time Os in many respects are just as vulnerable the full-time Medical Officers.

1065. You also recommend clearer finition of the rules and responsibilities of e Prison Medical Service, and that should clude a code of practice for the medical eatment of inmates. Could you expand on at point?

*(*Mr *Cooper.)* It is not something I ould like to expand on in great detail t what was behind that was our view of e need to be clear on the separation tween medical aspects and the discipli- ary regime of the prison. The fact is that otentially we do not believe in practice ere is a very big problem but there is otentially; the sort of thing that is occa- onally said about the use of drugs, for stance, to keep prisoners quiet. We felt was necessary if only to make sure that ublic disquiet was met, that there was a ear code of practice to distinguish be- veen the medical and disciplinary as- ects, but having said that I would not ant to go into any more detail at this age. It is something we want to sit and lk about in some detail.

1066. What about the medical records? You recommend a code of practice relating to that.

*(*Mr *Cooper.)* Our view is that the current position as far as medical records in prison are concerned is that it is appalling; they really are quite disgusting. It is appalling that records should be in such a poor state or non-existent. We are suggesting they should be at least as good as those for the rest of the population.

1067. You say medical records are non-existent in some cases. What sort of evidence have you got of the overall picture of the state of medical records?

*(*Dr *Garwood.)* They are fragmented, which is the main problem. The Committee may be aware of the F1150, the main prison record, which contains some medical pages, and those are the medical pages which are used by the doctor to record his findings when the prisoner first arrives in prison. If the prisoner requires medication or if he reports sick with a complaint then the doctor, the first time, is faced with a blank card—the record which he filled in with some care and in some detail on the prisoner's arrival is not routinely available to him. That is the first big problem. Further fragmentation occurs in that the small cards, called Cardex, which are used, because of their limited physical size, only have a few summary notes. So if, for instance, there is an orthopaedic problem which requires referral to an orthopaedic specialist, a third record has to be started called a hospital case paper, and this would have the appearance of a conventional outside National Health Service hospital folder. So, there you have three basic sorts of medical record. Although it is possible to get together the Cardex and the hospital case papers, it is very difficult to get the original main prison record together with the inmate when required for a further consultation. There is real difficulty in this fragmentation.

*(*Mr *Bland.)* As a pharmacist I am very familiar with some of Dr Garwood's problems, and I find this fragmentation time-wasting and possibly potentially dangerous. The information on the Cardex is in two forms, I find. We can have a diagnosis and a treatment prescribed by the Medical Officer, and if this treatment is continued for any length of time you can often find that a second card is needed to record the patient taking his medication. So you find a hospital officer, one of the nursing staff, is

[Mr Galley *Contd.*]

transferring information on to a Cardex, and my experience is that if I want to have a clear view I have always got to go back for the case paper, but quite often the Medical Officers and hospital officers come to me for fairly comprehensive information quickly, and I find that I can get that from my pharmacy records quicker than I can from the other two documents, and yet I am doing this manually.

Chairman

1068. You have them well-trained!

*(*Mr *Bland.)* I think I am well-trained and I think my staff are well-trained, because I do not think this information is always available in every prison hospital.

1069. Which prison are you from?

*(*Mr *Bland.)* Wormwood Scrubs.

1070. We went there, but I do not think we saw you on that occasion?

*(*Mr *Bland.)* I was sorry that you did not.

1071. It depends who is there on the day we go! The evidence says in paragraph 6.3 that records are not subject to the normal requirements of medical confidentiality. Is there not an ethical position here?

*(*Dr *Garwood.)* I think this refers principally to the first type of medical record that I mentioned, that which is contained within the main prison record. The top of those particular pages is marked confidential but they remain within the main prison record which is handled by Prison Officers and the clerical staff, and it is to this extent they are not subject to the same degree of confidentiality which, shall we say, a National Health Service general practitioner's records or National Health Service hospital records would be subject to.

1072. That is rather curious. Can I just go back to this question which I put to you about the problem of a Prison Officer being there to escort you, the doctor, if you want to go into the cell to talk to the prisoner or to deliver some kind of treatment. What is the ethical situation there? If you cannot see the patient, what do doctors do about it? Are you not worried about it, because the potential patient may be in very great difficulty or pain and yet the doctor cannot go to him if there is not an officer to escort him into the cell and presumably stay there while the doctor is with the prisoner?

*(*Dr *Garwood.)* It is a source of great concern.

1073. What are you doing about it? I not mean you personally, but what are prison doctors doing about it?

*(*Dr *Garwood.)* They are making strongest representations to the medi directorate for increased staffing to all the Medical Officer to see the patient.

1074. You mean more Prison Officers be available?

*(*Dr *Garwood.)* Correct.

*(*Mr *Cooper.)* It is fair to say that t problem is well-known and it has be made well-known by the prison docto The solution is something which is not their hands but it has been brought to t attention of everybody concerned.

Sir David Price

1075. Is the reason for this rule t protection of the Medical Officer becau he might be set upon by the prisone patient, or is it because the Medical Offic is not trusted? What are the reasons?

*(*Dr *Garwood.)* I think the reasons a threefold. You have mentioned two. The is the physical safety aspect. There is t potential danger that accusations cou subsequently be made against the Medic Officer, and there is the third point, gener security.

Chairman

1076. The doctor might be overpowere

*(*Dr *Garwood.)* He might be overpower and the prisoner might make an attempt t escape or take the doctor hostage.

1077. I am surprised at the second reaso you gave, charges might be made again the doctor?

*(*Dr *Garwood.)* Indeed.

1078. What sort of charges?

*(*Dr *Garwood.)* Charges of improper pra tice, shall we say, improper behaviour. might be physical injury to the patient improper conduct of any other sort.

Mr Kennedy

1079. You suggest that Prison Medic Officers should be able to work regul sessions in the NHS. I think you talk abo a sessional arrangement for them to stay i touch with developments for all sorts o good reasons. How much time? Let us sa for argument's sake, it was on a session basis and there was such an arrangemen how much time would they spend, wh

Mr Kennedy *Contd.*]

ould be your preference in terms of their ›ing into the Hospital Service, or would ›u prefer general practice, or would it, in ct, be as broad a spread as possible?

*(*Dr *Garwood.)* I am sure as broad a ›read as possible would be the answer. ne session per week would be very wel-›me.

1080. But do you think, if it was as :gular as that, that in fact you would be nding up with Prison Medical Officers who ight be very well in touch with the goings n in the Health Service generally but who ould, in fact, be veering towards becoming ightly part-time in terms of their own part n the Prison Medical Service?

*(*Mr *Cooper.)* I do not see any reason why ey should be at all. Already the Prison ledical Service uses doctors from outside n a sessional basis. We are suggesting that ie process can be reversed also for the ood of the people inside. It is something we ggest not just in terms of the Prison ledical Service but throughout the Civil ervice for all sorts of people. It is a very ood idea that people should maintain ontact with their general wider profession nd it is a balance that has to be met. As to ow precisely you do that, we would want › see it done to the greatest possible extent nd in the widest possible way.

Mr Yeo

1081. Why do you propose that the umber of full-time pharmacists in the rison Service be increased by twenty?

*(*Mr *Bland.)* I did not choose the number wenty, but I support the view that the umber of full-time pharmacists should be ncreased. The organisation of the Pharma-eutical Service is that we have a pharma-ist in the larger prisons who supervises the maller prisons in a geographical area. At he moment we are working on much the ame staff as we had, certainly to my nowledge, ten years ago. We have an ncrease in the prison population and the vork is just not being done as we profes-ionally would like it to be done. I know hat I do not do many things as I would refer to do in my own prison because I am usy caring for the medical needs initially f the patient rather than doing long-term lanning, trying to streamline the situation nd do more training for staff and hospital fficers. It is just that the workload seems to ave escalated almost to the point of the ystem breaking down. We are skating on uite thin ice, I think.

*(*Mr *Cooper.)* Our view is on both the medical side and the pharmacist side the resources have increased to a very small extent while the prison population has increased over the same period of time by 40 per cent or so. The workload has gone up very dramatically. The number that we put in our evidence is no magic figure at all; we simply suggested a fairly modest increase to that number would get to about the same ratio of pharmacists as there is in National Health Service hospitals, that does not make it a particularly magic number. We did not recommend that number, we simply said a modest increase would bring you up to that level, that is all.

1082. I just touched on distribution of this. Can you just enlarge on what you were about to say as to how the full-time posts would be spread around?

*(*Mr *Bland.)* I would think certainly we would want to put another full-time pharmacist into the South-East Region, probably at Maidstone. I am sure that the Midland Region could benefit from one or two more full-time pharmacists; the North Region certainly. These, I think, are the views which have been expressed over a period of time by the Head Pharmacist.

1083. Does that also reflect the prison population? Are you saying that where the areas of population growth have been greatest that is where you are putting these?

*(*Mr *Bland.)* I do not have access to those figures. I can only quote what the Head Pharmacist has led me to believe, that he would like these men certainly in the Midlands and in the South-East, and one in the North.

1084. You are not suggesting that the part-time pharmacist posts should be phased out?

*(*Mr *Bland.)* No. I would like to see an increase in the part-time pharmacist employment and I would certainly like to see an increase in the pharmacy technician employment because, in practice, a good full-time technician can take quite a burden off the pharmacist. Sometimes they are a little more effective than two part-time pharmacists covering the same number of hours.

1085. Some of the other witnesses we had complained that the prescribing figures produced by the Home Office are not very helpful. Is there any practical reason why

[Mr Yeo *Contd.*]

those figures should not be presented in a more helpful way?

*(*Mr *Bland.)* No. We were asked to collect the figures and I think the figures were collected so that you as parliamentarians can see the overall figures. It is a tedious job but something we do on a daily basis. Sometimes we are a little late in submitting our quarterly returns; like anything else they take their place in the routine. I would like to see in my own prison, and certainly in all the prisons that have full-time principal pharmacists, some computerised mechanical aids for us to collect and extract these. We are something of the order of two years behind our colleagues in NHS hospitals in the community in using machines to label medicaments for the patient's benefit. We now have technology which will allow us to do that labelling quickly and neatly and collect information about purchases, use, prescribing habits, and bring the statistics forward to a much more reliable degree, I think, than relying upon us as human beings remembering to write something down ten minutes after we have done the job. If the new system is devised, then, as with the old system, we shall do our best to make it work.

*(*Mr *Cooper.)* I suggest your question actually reflects back to the very f question you asked about availability clerical resources. It goes back again to problem of resources in collecting figu when people have other priorities.

Chairman

1086. I think that concludes our qu tions to you, Miss Winters and gentlem Thank you very much indeed.

*(*Mr *Bland.)* Before we are dismis could I make one comment here becaus do not think it is appreciated outside c own small group of people that the pris pharmacists are not civil servants; we a employed on NHS terms of service a have close links with our NHS colleagu but that does not mean to say we want join them. I would prefer not to.

*(*Mr *Cooper.)* One very short point: did not, in fact, present evidence to you the Prison Psychological Service becau that is not being looked into, but it has be mentioned by other people and I ju wanted to say very shortly that we represe the psychologists in the Prison Servic There is some concern about the interfa between the two Services and we would happy to present you with supplementa evidence on that if you so wish.

Memorandum submitted by the Association of Members of Boards of Visitors

SUMMARY

AMBOV welcomes the initiative of the Social Services Committee in deciding examine the prison medical service. It is a service sheltered from public scrutiny, hidd behind the double veil of Home Office and medical confidentiality.

A great deal of excellent medical care takes place within the prison service, and mar inmates receive treatment during their period of imprisonment for ailments which they ha neglected while they were at liberty. However, the reticence practised by the Home Offic and the lack, quite often, of suitable avenues for redress when problems do arise, increa the suspicion with which treatment in a totally closed instutition is viewed.

The recommendations which AMBOV puts forward are based on two premises:

i) Following Lord Wilberforce's assertion that "a convicted prisoner, in spite of h imprisonment, retains all civil rights which are not taken away expressly or b necessary implication", we believe that prisoners have the same rights to medica care as the rest of the community.

ii) We believe that all those working within the prison medical service are entitled t congenial working conditions and a recognised career structure.

We believe that these conditions cannot be met while the prison medical service i isolated from the main body of medical practice, and our main recommendation therefor is that:

1 *The prison medical service should be merged with the National Health Service, an*

sponsibility for the treatment of prisoners should be transferred to the Department of Health nd Social Secutity

In this paper we examine many aspects of the prison medical service, with examples rawn from the experience of our members.

HE ASSOCIATION OF MEMBERS OF BOARDS OF VISITORS—WHAT IT IS

AMBOV is a voluntary and independent association of individual members of Boards. Members pay an annual subscription.

Members of Boards of Visitors are appointed by the Home Secretary as the watchdogs of he prison service. Their duties are defined in Prison Rules 94–96:

94.(1) The Board of Visitors for a prison shall satisfy themselves as to the state of the rison premises, the administration of the prison and the treatment of the prisoners.

(2) The Board shall inquire into and report upon any matter into which the Secretary of tate asks them to inquire.

(3) The Board shall direct the attention of the Governor to any matter which calls for his ttention, and shall report to the Secretary of State any matter which they consider it xpedient to report.

(4) The Board shall inform the Secretary of State immediately of any abuse which comes o their knowledge, and shall have power in any case of urgent necessity to suspend any fficer until the decision of the Secretary of State is known.

(5) Before exercising any power under these Rules (other than Rules 51, 52 and 56) the Board and any member of the Board shall consult the Governor in relation to any matter which may affect discipline.

95.(1) The Board of Visitors for a prison and any member of the Board shall hear any complaint or request which a prisoner wishes to make to them or him.

(2) The Board shall arrange for the food of the prisoners to be inspected by a member of he Committee or Board at frequent intervals.

(3) The Board shall inquire into any report made to them, whether or not by a member of the Board, that a prisoner's health, mental or physical, is likely to be injuriously affected by any condition of his imprisonment.

96.(1) The member of the Board for a prison shall visit the prison frequently, and the Board shall arrange a rota whereby at least one of its members visits the prison between meetings of the Board.

(2) A member of the Board shall have access at any time to every part of the prison and to every prisoner, and he may interview any prisoner out of the sight and hearing of officers.

(3) A member of the Board shall have access to the records of the prison.

BOARDS OF VISITORS AND THE PRISON MEDICAL SERVICE

The duty of boards to satisfy themselves about the treatment of prisoners must certainly include medical treatment; but they find it difficult to carry out this part of their duties adequately.

A recent report[1] for the Home Office research and planning unit found that "Medical problems are a headache for boards because it it very difficult for them as laymen to

question the uses of medication, the necessity for treatment, and so on, from the point view of their own expertise; but more importantly, because medical staff are not of willing to submit their professional judgment to lay examination." The same report sho that 17 per cent of applications by prisoners to Boards of Visitors concern medi treatment.

In theory Boards of Visitors can refer a medical matter directly to the Regional Medi Officer. In practice the governor and prison medical officer would consider t discourteous, unless a complaint is abundantly and transparently justified. Boards disc medical matters with the governor and prison medical officer, and have to be satisfied w explanations at that level. Without formal access to a second professional opinion, it difficult for lay Board Members to assess inmates' complaints.

Most Boards find it difficult to take suitable action, even in cases where they feel th assistance to the prisoner seems appropriate. Prison Governors are inclined to say that t medical officer has full autonomy over all medical treatment, and stress the confidential of medical information. In general medicine it is the patient who has a right confidentiality, so that with the consent of the patient any facts may be disclosed. Howev within the prison medical service "medical confidentiality" is, we feel, a term more used defend secrecy.

Cases where an inmate asks for a second opinion can only be dealt with by the Board the prison doctor concerned agrees. Remand prisoners have a right to seek any medic advice they wish but, since they must then pay the full cost doing so, the right is of lit value in practice. Problems arise when prisoners who have been receiving treatment for ailment outside prison are then given different treatment by the prison doctor. Many pris doctors disregard the prisoner's request for a continuation of the previous treatme Prisoners unhappy with their treatment often turn to the Board of Visitors for help, b subsequent questions from the Board are seen as interference with clinical judgment.

We therefore RECOMMEND that:

2 *The role of Boards of Visitors should be recognised and, if necessary, extended so as enable them to inquire into medical concerns of inmates.*

3 *Every Board of Visitors should have the right to call in a doctor from outside t establishment to assist them if they think fit.*

The Medical Officer

In 1984, the prison medical service had 79 full-time and 98 part-time doctors—the latt mostly NHS general practitioners with part-time contracts. These doctors had approx mately 44,000 prisoners to look after. In the general community, 20 doctors would b allocated to look after this number. There is some evidence that prisoners have a high incidence of illness than do their counterparts in the general community[2] but th difference in numbers can mainly be accounted for by the wide range of tasks carried ou by prison doctors.

The prison medical officer has a number of different responsibilities. These fall int various categories, viz:

i) The health of prisoners
ii) Provision of necessary reports to Courts, Parole Board, etc
iii) Hygiene of the establishment
iv) Advice to the Governor on all medical matters
v) Provision of medical supervision in all areas within the prison
vi) In many cases, Winchester, for example, the senior medical officer has direc responsibility for the medical facilities in a number of other widely spaced prisons thus reducing very materially the time he can spend at "his own" establishment.

All prisoners are examined on reception. Given the numbers involved, this is often a very rsory examination, and the doctor is dependent to a large extent on information given by e inmates. For example, at Wormwood Scrubs it is not unknown for upwards of fifty mates to be examined in the space of an hour.

A large part of the time of medical officers is taken up with the writing of reports. A study Leeds Prison shows that almost half of the full-time medical officer's time is spent on oviding reports. There seems to be no way of avoiding this demand on their time, since edical reports –especially psychiatric reports—are requred for decisions concerning ication, parole, etc.

In each establishment the medical officer is responsible for inspecting and reporting on e hygiene within the establishment, and on general standards of health. However, there is o independent measure against which standards in the prison can be assessed. Doctors port regularly on matters which they find particularly unhygienic, but it is difficult for em to insist on higher standards, or on a more healthy type of regime. Poor sanitary rangements, the restricted use of disinfectants, overcrowding, limited exercise, limited posure to fresh air, and even to sunlight, are bound to have an effect on physical and ental health. A minimum standards code would give medical officers a standard against hich to measure conditions in their establishments. It would also help Boards of Visitors monitor health care.

We therefore RECOMMEND that:

4 *A code of standards should be drawn up for prisons which should contain minimum andards for physical surroundings and for the treatment of prisoners. The code should set andards at least as high as those put forward by the Council of Europe.*

5 *Local Environmental Health Officers should have a duty to report on prisons, employing e same standards for health and hygiene as those applied to comparable establishments in the cality, and Crown immunity should be abolished.*

Prison doctors are expected to pronounce on many applications from inmates, even hen the question at issue is only peripherally medical in nature. For example, applications e made by inmates who find prison-issue plastic footwear uncomfortable; by some who el the cold particularly badly and request warmer clothing; by vegans who need special tamins to supplement their diet; by inmates who believe that a particular workshop dversely affects their health: all such applications are referred to the medical officer. Often he doctor states that there is no *medical* reason for the request, and refers the matter back o the Governor, who claims that this is a medical matter . . . and so on. The Governor's roblem is one of maintaining uniformity and equity throughout the establishment, oupled with a natural reluctance to take any decision which might properly be seen as ing within the professional competence of the medical officer. The doctor, on the other and, may well feel that it is no part of medical expertise to advise on such matters. One rincipal Medical Officer has remarked that his staff are not shoe salesmen, and that most f them trained in countries where very few people possessed shoes at all.

We therefore RECOMMEND that:

6 *While Governors should always seek the opinion of the Medical Officer in matters of a uasi-medical nature, the Governor should ultimately take responsibility for the decision eached.*

One matter which particularly concerns AMBOV is the uncertain position of the medical eam within the prison hierarchy. Prison doctors are employed by the Home Office, and not y the DHSS as are doctors in general practice or in NHS hospitals. Doctors in the prison ervice are independent where clinical decisions are concerned, but are under the control of he Governor in other matters. This causes an ambivalence in their relationship with nmates, since the doctor is both personal physician and at the same time part of the isciplinary procedure. We can see no way in which the prison doctor can escape this ilemma. There is a particular dilemma for doctors working in a prison where protective

cells for disruptive inmates are in the hospital (e.g. Ashford Remand Centre). In such cas the hospital may come to be regarded by prison officers and inmates as a step up in t disciplinary procedure from the segregation unit. It is not unusual for severely disrupti prisoners, initially located in a protective cell in the hospital, to be found subsequently n to be psychiatrically ill.

We do not believe that it is in the best interest of doctors or inmates for the doctor wl advises the Prison Governor also to act as personal physician to inmates—the rule th doctors must certify prisoners fit for punishment before they are adjudicated upon f disciplinary offences is almost a travesty of the role of personal physician. We believe th inmates have a right to treatment which is based on their needs, and not on the needs of t establishment; and that it is in the best interests of all concerned for such treatment to l given, and to be seen to be given, in response to their needs as patients.

We therefore RECOMMEND that:

7 *Doctors treating inmate-patients should be employed by the DHSS, and should be bou by the same criteria and ethics as those obtaining in the rest of the NHS.*

Until such time as doctors working within the prison are employed by the DHSS, ar subject to the same lines of accountability, there remains a problem of accountability in th prison medical service. The Prison Medical Officer is responsible to the Regional Medic Officer, and both are employed by the Home Office. The only outside monitoring (oth than the BOV) is by medical inspectors on the staff of HM Prison Inspectorate. Th Hospital Advisory Service, the Health Services Commissioner, the Family Practition Committees, the Community Health Councils, and the Mental Health Commission hav no remit over medical care in prisons. Inmates, unlike most patients, suffer from the furth restriction that they cannot change their doctor, nor have they easy access to a secon opinion.

It is against this background that AMBOV would like to see an early revision of th prison medical service, and more clearly defined lines of redress. We belive that most of th medical care offered within the prison medical service is good, and comparable to tha offered by the NHS. We also recognise that the inmate population contains a higher tha average percentage of litigious and argumentative people with a great deal of time to broo over minor injustices.

Nevertheless we believe that it would be helpful for all concerned if the prison medic service were seen to be more accountable.

We therefore RECOMMEND that:

8 *Further and urgent consideration, in advance of any possible action along the lines of o Recommendation 7, should be given to ways in which prison medical officers can be shown t be more accountable for their decisions. We believe that they should be accountable to th same monitoring and inspecting bodies as are their colleagues in the NHS.*

AMBOV is concerned at the lack of contacts between doctors in the prison service an their colleagues in the NHS. We believe that it is in the interest of both services for there t be close co-operation and sharing of ideas. We know that previous efforts to encourag closer links between the two services have made no impact, and recognise that true co operation may have to await the merging of the two services. Nevertheless we believe tha the exchange of ideas is sufficiently important to merit further efforts.

We therefore RECOMMEND that:

9 *Closer links should be built between the prison medical service and other fields of medic practice. Doctors should be enabled and encouraged to share their expertise and their concern with doctors working in other settings.*

URSING STAFF

In male establishments the majority of the staff in the prison hospital consists of hospital ficers—that is, discipline officers who have undertaken a short period of training in ursing. Most of them are dedicated people who genuinely try to help their patients in tremely difficult circumstances, but they are sadly lacking in formal training. The esent training period is *six months*, but most of the officers in post trained some time ago, nen a much shorter training period was allowed. It was only in 1983 that the training riod was increased from *13 weeks*. Some hospital officers have also undertaken refresher urses, usually lasting a maximum of one week. This training compares with a minimum aining period of *two years* for the lowest grade of qualified nurse (SEN) in the NHS.

Despite their minimal training, hospital officers in the prison service are called upon to rform a wider range of tasks that all but the most experienced qualified nurse would be pected to attempt in an NHS hospital. They dispense drugs, give injections, suture ounds, insert temporary dental fillings, and may have to wash out the stomach of an mate who has taken an overdose.

Reference to the suturing of wounds by hospital officers can be found in the Report of an quiry into the Disturbances at Wormwood Scrubs on 31 August 1979:

"The duty medical officer was aware that hospital officers were suturing wounds received by prisoners and was content that this should continue particularly as it did not mark a departure from normal practice at Wormwood Scrubs. The majority of injured prisoners suffered bruising, but nineteen prisoners required sutures, all for head wounds."

At Dorchester Prison a member of the BOV reported seeing a prisoner who had tempted to commit suicide having his wrists sutured without the benefit of anaesthetic. nce this procedure was being carried out on the orders of a Medical Officer, the BOV ember felt powerless to intervene. The matter was subsequently reported to the Regional ledical Officer, who saw no reason to take any action on the matter. We doubt whether is procedure could have taken place in an NHS hospital.

Hospital officers are responsible for dispensing drugs, usually in liquid form, which have en prescribed by the doctor. They can also dispense a range of simple drugs without course to a doctor. These simple drugs are mostly those which can be bought without rescription, and which are in general use as household remedies, but which are denied to risoners except by reporting sick. In addition, it is not unknown for senior staff in some risons to request hospital officers to dispense sleeping pills or tranquillisers for an inmate ho is upset, perhaps by bad news. In an establishment where there is a relationship of ust between doctor and officer it is accepted that the officer will dispense the drug quested and that the following day the doctor will legitimise his action by a backdated rescription. This could not happen in the NHS, where no nurse would have the power to ispense prescription-only drugs.

The area in which prison hospital officers have most specialised experience is in the care f mentally ill, violent, or subnormal inmates. With the present trend to close down ospitals for the mentally ill and mentally handicapped, an increasing number of people eeding the asylum that those institutions offered are being received in prison. Prison ospital officers are therefore left to care for many people who cannot be cared for in the HS.

AMBOV regrets that these officers are not encouraged to gain qualifications as general or sychiatric nurses. Such a qualification would have many advantages. Firstly, the care and oncern shown by many officers is not backed by sufficient theory to enable them always to se their abilities to the full, and further study would help them to do that. Secondly, the ward of a recognised qualification would increase the status of Hospital Officers, and ould help to give them a firmer career structure. It would also allow officers leaving the rison service to have a transferable qualification which could be recognised in the outside orld. And, thirdly, the training process could help to increase the co-operation between rison hospitals and the NHS. The benefits to the prison hospitals would be enormous, but here would also be great benefit to the NHS hospitals, especially those setting up secure nits for difficult or violent patients.

At the present time, hospital officers who elect on their own initiative to take a full tim nursing course have their pay reduced to that of a student nurse, and also have to pay rer to the Home Office for their accommodation. We find this attitude of the Home Office ver short-sighted.

We therefore RECOMMEND that:

10 *Hospital Officers should be encouraged to seek further training, and should be seconde to do so at agreed rates of pay, with no additional charge for rent.*

11 *More hospital trained nurses should be recruited to the prison service.*

Women in Prison

In women's prisons the hospitals are staffed by NHS-trained nurses. This ensures tha inmates are cared for by qualified staff, though the prison conditions are sufficientl unattractive to cause a high turnover of nurses. Friction has been known to arise betwee nurses, who are part of the medical team, and the prison officers who retain responsibilit for security, and so must accompany the nursing staff, locking and unlocking doors fc them.

We therefore RECOMMEND that:

12 *Qualified nurses should be recruited to the prison service, and given a short course i security techniques.*

13 *Pay and conditions for nurses in the prison service should be upgraded to encourag nurses to remain in the service.*

It is sadly true that frequently neither nurses nor prison officers have training o experience in mental illness. We await the report of the enquiry into C1 wing at Hollowa Prison, and hope that it will contain positive suggestions for improvements in the treatmen of mentally ill women inmates. We hope that many of the recommendations would also b applicable to mentally ill male inmates.

Many of the medical treatments in female establishments are related to the menstrua cycle (e.g. contraceptive pills), but the treatment cards are inadequate to record this. Th cards are the same as those used throughout the prison system, and are typical of a male oriented service.

We therefore RECOMMEND that:

14 *Medical cards suitable for female patients should be brought into use in femal establishments.*

Paramedical Services

(a) *Psychologists*

In 1982, there were about 90 psychologists in the prison service. (In the NHS there is only one psychologist for every 46,000 of population.) In 1980 an internal review of the prison psychological service recommended that "the main role of prison psychologists should lie in organisation and system centred tasks". AMBOV would like to see the psychologists more involved in patient therapy.

A good example of how a psychologist can help comes from Bullwood Hall. Members have commented on the help a senior psychologist was able to give to young women with self-inflicted injuries. They report that, thanks to his intervention, the spate of such injuries was much reduced. Unfortunately, this man left and was not replaced.

(b) *Radiology*

X-ray equipment is present in the hospitals of some prisons. The major prison hospitals have fairly sophisticated x-ray facilities and use qualified radiographers from local hospitals. In many small prison hospitals a mobile x-ray unit is provided on which certain x-ray examinations are conducted by Hospital Officers. These officers have undertaken a *two-week course* which includes not only use of the equipment, but also the processing of radiographic film. Such training must be compared with that of a state registered radiographer who has a minimum of *three years training*, and would be expected to have further experience before working in a single handed situation. We believe that such unsupervised use of potentially dangerous equipment involves a risk to patient, operator, and other staff from the effects of ionising radiation dispensed by untrained staff.

(c) *Other Paramedical Services*

Other paramedical services are almost completely absent from the prison medical service. Physiotherapy, occupational therapy and speech therapy are rarely available to inmates.

AMBOV believes that prisoners should receive medical care of the same standard as that available to the general community.

We therefore RECOMMEND that:

15 *Paramedical services should be provided in prisons for the same needs and with the same standard of training and equipment as those obtaining in the general community.*

Hospital Facilities

Prison hospitals range from fairly sophisticated establishments with an operating theatre to very small departments which could more reasonably be termed sickbays. Common to nearly all is a shortage of nursing staff. At Glen Parva Youth Custody Centre the hospital built three years ago has two wards which have never been opened because of staff shortages. At other hospitals the problem is particularly severe at night. At Northeye, for example, there are no staff on duty in the hospital at night, only an inmate-orderly who is on call. Pentonville also has very poor manning levels, particularly at night.

Physical conditions in most prison hospitals are depressing, and scarcely suitable for the promotion of good health. Many are old with poor sanitation. At Pentonville conditions in the hospital are described as unsavoury, and since there is no day room patients are locked up for most of the time. Leeds Prison is an old cheerless building with single cells, and, like many old prison buildings, is dependent on "slopping out". We deprecate the practice of "slopping out" in any part of the prison service, but it is particularly out of place in a hospital.

In some prisons the combination of staff shortages and unsuitable buildings produces particularly unhappy results. This is true of the newly built C1 wing at Holloway, where there is no association area and only small cells. The intention was that inmates should be out of their cells all day in workshops, gymnasium, swimming pool, etc. Such a regime would be possible only with a high ratio of staff to inmates. The reality is different, with women locked up for long hours each day.

One problem which worries both staff and BOV members in several prison hospitals is the poor facilities for observing ill patients. With individual cells and locked doors, patients are often out of sight of the staff. At Norwich Prison poor observation was responsible for an incident in which a sick and frightened prisoner was injured by another, both being out of sight of the nursing staff.

We prefer the use of outside hospitals for prisoners whenever possible, but recognise that problems of security and administration will ensure that many prisoners continue to be treated within the prisons.

We therefore RECOMMEND that:

16 *Staffing, equipment, and facilities in prison hospitals should be up-graded to a suitabl standard.*

17 *An additional budget should be made available by the Home Office for the up-gradin*

18 *Small or poorly equipped prison hospitals should be regarded as sick bays, and shoul not be used for patients needing hospital care.*

19 *Clear observation of patients should be made a priority, and such adaptations as ar necessary should be made.*

MENTAL ILLNESS

Mentally disordered inmates present one of the most worrying aspects of prison. It i difficult to establish the exact number of such patients, since present methods of collectin statistics are generally agreed to be unreliable. However, Home Office figures show that ir 1984 there were 310 inmates classified under the terms of the Mental Health Act 1983. Ir addition, there were many inmates with personality and/or behaviour problems abou whom members of Boards of Visitors have expressed extreme concern.

In theory mentally disturbed prisoners do not lack facilities. Three levels of provisio exist:

i) For violent insane patients, whether criminal or not, there exist the special hospitals These cater for a small minority of deeply disturbed patients, and AMBOV does no favour any extension of their role.

ii) Regional Secure Units, attached to general psychiatric hospitals, should be able t cater for the majority of disturbed violent patients. However, although money ha been provided by the DHSS, Regional Health Authorities have failed to provide the agreed number of beds. In 11 of the 14 regions, little more than one third of the agreed beds have been provided, while only two regions have any beds in menta handicap hospitals. Admission practices vary widely between the regions—fo example, some Regional Secure Units do not admit mentally handicapped patients however violent. Even when all the promised beds are provided it is unlikely tha Secure Units could entirely solve the problem of mentally ill people in prison.

iii) For those classified mentally ill under the Mental Health Act 1983, there is the possibility of transfer to DHSS psychiatric hospitals. But Home Office statistic show that a good proportion of those classified remain in prison. Psychiatrist invoke the "treatability" clause to refuse admission and, to be fair, the open regime policy of ordinary psychiatric hospitals conflicts with the need for security. Patient who can be transferred must await a bed, and the waiting period is determined b the level of psychiatric provision in the area. It often lasts for several months.

As a result, prison staff have to cope with problems for which they are not equipped. The BOV at Bedford was seriously concerned recently about an inmate who was held for nearly eight months in an unfurnished room. In spite of all efforts by the prison, no hospital could be found to take him. This not only put great strain on the prison staff, but also caused deterioration in the condition of the prisoner.

Remand prisoners fare no better than convicted prisoners in this respect, and have in addition to cope with the worries of a forthcoming trial. The Mental Health Act 1983 allows for remand to a psychiatric unit for pre-trial assessment but, regrettably, this provision has been little used to date. Hospital beds are not usually available, and the remand is therefore to prison. In a recent article[3] Audrey Peckham condemns such remands from the point of view of an inmate who has experienced the regime. From a different point of view, a member of Wincheaster BOV has expressed concern about an apparent manic depressive who had to be locked up for 23 hours a day. Here the problem was not due to lack of care on the part of prison staff, but to overcrowding resulting in an inability to accommodate the prisoner in a way which would not aggravate his condition.

All top security prisons face the problem of containing inmates who resort frequently to angerous and unreasoning violence. Many of them are labelled psychopathic, and are not xpected to respond to psychiatric treatment. They therefore remain within the prison ystem, spending most of their time in segregation, being unlocked only in the presence of erveral prison officers. On release, they have even less experience of normal human elationships than have the rest of the prison population. We believe that some training in uman relationships and in alternative outlets for aggression must be offered to such men, oth for their own sakes and for that of the society to which they will eventually return.

We therefore RECOMMEND that:

20 *The DHSS should be made responsible for ensuring that secure accommodation with a herapeutic regime is made available for all violent prisoners.*

Many prisoners, while not classified as mentally ill in terms of the 1983 Mental Health ct, nevertheless display bizarre behaviour problems. They may suffer from neurosis, eneral depression or personality disorders, while some are drug addicts, glue sniffers, lcoholics, sex offenders, etc. Some of these may be offered treatment at Grendon nderwood, but facilities there are restricted to men whose condition is treatable and who ave a sentence of at least two years. We should like to see Grendon Underwood used more idely as an assessment centre, with a view to sending some of the inmates out for reatment in NHS hospitals.

We therefore RECOMMEND that:

21 *Grendon Underwood should be more widely used as an assessment centre.*

It must be accepted that the general inmate population is likely always to contain a high roportion of people with mental problems. Richard Smith[4] examined all the recent tudies of the mental health of prisoners, and concluded that "Many prisoners are anxious nd depressed, many of them have abnormal personalities, and more of them are mentally ubnormal than in the community . . . The high levels of mental abnormality seen among risoners may be due to the mentally abnormal being more likely to commit crime or it nay be due to their being more likely to be caught and sentenced, or prison itself may roduce the abnormality. Probably all three factors contribute."

It is important, therefore, to consider the treatment which can be offered to inmates within the general prison population. The recent concerns about the C1 Unit at Holloway ndermine confidence in any plans to treat mentally disturbed inmates in the wing of an rdinary prison—the result, in the case of Holloway, seems to have been segregation, not reatment. More hopeful examples can be seen in the Wormwood Scrubs Annexe for drug, lcohol and sex offenders, the Barlinnie Prison special unit in Glasgow, and the wards at Glen Parva YCC for seriously disturbed trainees. Each of these units offers an environment n which inmates are able to confront their problems, and receive help in overcoming them, ut each suffers from a complete lack of after-care facilities. Just at the point when inmates re again exposed to the problems and temptations from which they have been sheltered in rison, they are denied the support of the unit which has been helping them. This has led ne member of Glen Parva BOV to question whether the unit was perhaps doing more arm than good, since it had allowed boys to overcome their defensive mechanisms without iving them time or adequate continuing support to rebuild their ability to cope with their ives.

We therefore RECOMMEND that:

22 *Pre-release hostels with therapeutic regimes should be set up as a stage towards release.*

23 *The pre-release hostels should also have facilities for released prisoners who remain voluntarily and who are still benefitting from the regime.*

24 *After-care arrangements should be offered on release to all inmates who have been in a prison therapeutic unit.*

There are also many inmates for whom a special therapeutic unit is unnecessary, but wh would benefit from a regime which was less rigid, and which allowed for the consideratic of personal problems. Manpower restraints are often cited as the reason why the priso regime is so restrictive, but we believe that there are many groups who could make mor contribution than is the case at present. Probation officers, education staff and priso chaplains could all help in this field if they were offered proper training, and there are som wing officers who would welcome the opportunity to offer more compassionate an understanding care. Leaders from Alcoholics Anonymous and Narcotics Anonymou already hold successful groups in some prisons, and we believe that this type of wor should be extended, possibly with the help of such organisations as Samaritans.

We therefore RECOMMEND that:

25 *Consideration should be given to providing adequate opportunities for all grades prison staff to train in counselling and other specialised techniques of therapy.*

Inadequate and Retarded Prisoners

Two groups of prisoners cause especial concern, partly on account of their high rate c recidivism. One group is that of socially inadequate inmates who have personalit problems; the other is the group of mentally handicapped inmates whose disability is not s severe as to indicate transfer to a mental handicap hospital. Unfortunately, our prisons d not encourage people to take decisions, to plan for themselves, and to foresee th consequences of their actions, so the prison regime cannot lead to any development fc such people in the way that a well-run psychiatric unit might. We fear that it is unrealisti to recommend that all such inmates are provided with a place in a psychiatric unit.

We therefore RECOMMEND that:

26 *Attention should be given to the teaching and training of socially inadequate an mentally handicapped prisoners. The medical service should co-operate with the educatio department to provide a co-ordinated service for all such prisoners.*

References

(1) Maguire and Vagg. The "watchdog" role of Boards of Visitors. 1984.
(2) Richard Smith. The Physical Health of Prisoners. Prison Health Care. B.M.A. 1984.
(3) Audrey Peckham. Passing through Purgatory. New Statesman. 21 June 1985.
(4) Richard Smith. The Mental Health of Prisoners. Prison Health Care. B.M.A. 1984.

Examination of Witnesses

Mrs Ruth Wainwright, Board of Visitors, Wormwood Scrubs, Dr Dennis Morgan Board of Visitors, Norwich Prison and Senior Consultant Psychiatrist at King's Lynn, an Mrs Sally Hartog, Board of Visitors, Pucklechurch Prison; Association of Members o Boards of Visitors, called in and examined.

Chairman

1087. Can I thank you very much for the very interesting documentation which you sent to us, which we read with very great interest. As with the previous witnesses, we would like to raise certain issues with you arising out of the evidence. Can I start off by your reference that 17 per cent of applications by prisoners to Boards of Visitors concern medical treatment in some form or other. Can you give us examples o the kind of complaints that you receive a members of the Boards of Visitors?

*(*Mrs *Wainwright.)* It is usually a change of treatment from that which inmate were receiving before they were in prison. This results in complaints about the treat ment they are receiving inside prison.

Chairman *Contd.*]

1088. Is it that they have checked with the doctor of the prison and found it is not the same?

(Mrs Wainwright.) Sometimes it is that they have checked and found it is not the same; sometimes the doctor is not prepared to discuss with them whether it is the same or not, they say it is the treatment available and that is all. It depends on the individual doctor. The treatment always looks different because if it is a medication it will always be in liquid form within the prison.

1089. That is for obvious reasons.

(Mrs Wainwright.) That is right.

Sir David Price

1090. Is it particularly the change of drug, because one knows there are alternative drugs for the same treatment, and a change of drug can have side effects?

(Dr Morgan.) It is a change of drug and cessation of drugs which the GP outside the prison was giving. This could be tranquillisers when somebody is waiting to go in prison and they are taken off them when they get to prison. We understand the sorts of reasons for giving such drugs. Then there are simple medications for dyspepsia, which they are taken off. There are other complaints which are not so much about drugs but things like chronic back aches; points about dental treatment which were mentioned by the previous witnesses, and other conditions which they feel should be leading to a quicker referral to outside hospitals.

(Mrs Wainwright.) There is also the question of complaints which are not really medical but which get passed to the doctor by the disciplinary staff. There are regularly complaints about the shoes, people who feel they cannot wear prison-issue shoes for whatever reason.

Chairman

1091. They always have my sympathy! Mine are large and broad, so it is always a problem!

(Mrs Wainwright.) The Governor grades will say, "If you cannot wear prison-issue shoes, then that means there is something wrong with your feet. You will have to see the doctor." Then the doctor says, "There is nothing wrong with your feet." They go backwards and forwards and this may go on a long time.

1092. Causing a lot of misery for the sufferers. What about complaints from women prisoners? Are there any particular complaints from them?

(Mrs Hartog.) Women in prison often have more problems which they bring in with them—we certainly do get gynaecological complains—but whether this is very different from the complaints which male prisoners have, I do not know.

1093. Do you deal with women prisoners, Dr Morgan?

(Dr Morgan.) No women at all. I see none at Norwich, which is the prison I particularly attend.

1094. Women do go into prison being pregnant and have the problem of going out of prison to have their baby and then coming back with the baby into prison. Have you experience of that?

(Mrs Hartog.) No. At Pucklechurch we do not have a mother and baby unit. We have pregnant women but they will be transferred to another establishment near the time of their confinement.

1095. Where do you send them? Holloway?

(Mrs Hartog.) Yes, or Styal. I think Bullwood has a mother and baby unit.

1096. Then they come back, do they?

(Mrs Hartog.) No, we do not have babies at Pucklechurch, except in very occasional circumstances.

1097. How often do you have complaints about the serious mistreatment of prisoners?

(Mrs Hartog.) Women particularly?

1098. Or men?

(Mrs Wainwright.) I cannot think of incidents of serious medical mistreatment.

1099. What about you, Doctor?

(Dr Morgan.) Very rarely indeed. We have discussed one or two between ourselves but it is very rare there is a serious incident. There are sometimes accusations by prisoners which have to be looked at in the normal course of adjudication of false charges laid against officers, which become disciplinary ones.

1100. How often do these happen?

(Dr Morgan.) About once every two months in each individual institution, but more often than not there are small inci-

[Chairman *Contd.*]

dents like prisoners throwing hot tea over other prisoners, but these are easily dealt with within the Prison Service itself.

Mr Winterton

1101. How many of the allegations which are made are ultimately substantiated? Even if they are not fully substantiated, that there is an element of truth in what has been said?

*(*Dr *Morgan.)* I think the balance tends to be against the prisoner and in favour of the system, and there are times when members of the Boards of Visitors feel the balance has gone wrong and one has to redress it. That is difficult but one has to do this, by virtue of seeing that the prisoners get a fair hearing and are looked after properly. One has to redress the balance and where there has been aggression against a Prison Officer this could be because the Prison Officer's own handling of the prisoner could have been highly provocative; for example a man known to be on a short fuse but who is not really aggressive. We try to be impartial but know that at times one has to stand up for the prisoner.

1102. Do you think the system creates a situation where some of the complaints that might be made are not made, ie are you concerned that there may be incidents of ill treatment of any form which do not come to you because of the system?

*(*Dr *Morgan.)* I think very few indeed but there are one or two. I think Mrs Wainwright was involved in an incident several years ago.

*(*Mrs *Wainwright.)* Yes. Rule 48(12), which is notorious, makes it difficult to say with certainty that there are not cases that do not reach us. That is a bit negtive but obviously we do not know about what we do not know about.

Chairman

1103. What about complaints about medical mistreatment?

*(*Mrs *Wainwright.)* That is how I had interpreted your question originally, and that is where I cannot think of any cases.

Sir David Price

1104. What is rule 48(12)?

*(*Mrs *Wainwright.)* The rule which makes it a punishable offence for a prisoner to make an allegation against an officer which is false and malicious. As soon as the prisoner says that he wants to make some allegation against an officer, this rule is immediately quoted at him: "You reali you may not make an allegation which false and malicious. Of course we will lo into your complaint and investigate it, b you do realise if it were found to be fal and malicious . . ." et cetera, et cetera. Th is a great difficulty.

Mr Winterton

1105. This is the system to which I w referring, that there is, as it were, a disince tive to inmates, prisoners, to make cor plaints. Do you want to see that changed

*(*Mrs *Wainwright.)* Very much.

Chairman

1106. In your paper you said that Boar of Visitors find it difficult to assess priso ers' complaints about medical treatme and you recommend they should ha formal access to a second profession opinion. Perhaps you would like to tell how you would see that operating. Wh would give the second opinion in yo view?

*(*Mrs *Wainwright.)* Our main recomme dation is that medical treatment of priso ers should be in the hands of doctors wh are employed in the National Health Se vice or, at least, by the DHSS and, ther fore, how that—

1107. In the same way as you bring in second opinion in the Health Service?

*(*Mrs *Wainwright.)* That is right.

*(*Dr *Morgan.)* This partly developed b cause in discussions between ourselves, wit my being in the unique position of being medical member and a psychiatrist on th Board of Visitors, I can listen to th complaints and sort them out, and I sai "We haven't had these problems at Norwic at all which you had elsewhere because have complete ease of access to the nursin officers in the prison hospital, and to th Medical Officers, I can talk with them wit the greatest of ease and there is almo nothing I want that is not cleared up betwee myself and them." That is one reason fo saying that if there were, not necessaril doctors, but a nurse on the Board of Visito in each case who had some knowledge, th would allow for clarification, contact an access which was acceptable.

1108. You think that would be a goo idea?

*(*Dr *Morgan.)* I think if there is no suc member doctors can put up their ow

hairman *Contd.*]

ofessional screen, whereas if there is such a mber there is an easy parlance between e two.

1109. You also say the Board of Visitors n at present refer a medical matter to the gional Medical Officer, but they rarely do because this might be considered to be courteous by the Governor and the Prison edical Officer, is that so?

(Mrs *Wainwright.)* Boards of Visitors are a very strange position within the prison d do tread extremely carefully, I think.

(Dr *Morgan.)* You can get some strange ison Medical Officers.

1110. You said it!

(Dr *Morgan.)* We are fortunate that we ve changed the Prison Medical Officer at rwich. By "we" I mean the Governor and hers. There is a vastly improved atmos- ere now, but before that change was made ere were very considerable problems with man whom I could technically call truly ranoid.

1111. Do you think there would be any fficulty if Boards of Visitors were given hts of access to second opinion? Would at cause any problems or any offence in y direction, do you think?

(Mrs *Wainwright.)* It is not so much the ed for a second opinion, as the right to tain independent medical advice. It needs be written into prison rules, as prisons are ry rule-conscious institutions. I think we st wanted the position strengthened so that could do this without causing offence.

Mr Winterton

1112. As somebody who is forever creat- g offence by the way I question, may I say, you really feel that from time to time you ay not need to be discourteous, as it were, at least forceful in order to do the b—and a valuable job, I believe—you are ere to do?

(Dr *Morgan.)* You do, indeed, have to be epared to be discourteous and to probe pleasantly at times. You hope that after at day is over you are welcome again.

Mr Kennedy

1113. Maybe I could move on with a urteous inquiry. You recommend that octors who act as personal physicians to mates should be employed by the DHSS and not be involved in prison management. Who would you then see advising the Governor on medical matters?

(Mrs *Wainwright.)* We are very anxious that the Governor's advice should include medical advice and that medical consideration should be included at all levels of management and, therefore, we can see that there is a role for Home Office employed doctors to take on that function. But we would like to see a distinction made between that role and the role of treating ill inmates. I suppose the nearest equivalent would be in the Occupational Health Service where you have doctors who are employed with an industry to advise the management but where workers go to their own doctor for treatment; that is the nearest equivalent we could see.

1114. Would that be liable to create an internal two-tier level of health advice and health treatment within the prison, do you think? Would that be a danger?

(Dr *Morgan.)* I think there would be some risk unless there was really good communication and discussion. There has got to be discussion by both parties involved with the Governor and both have to work within the whole bounds of the security of the establishment.

(Mrs *Hartog.)* In the case of small establishments where the general medical cover is performed by part-time GPs I think there is that division already because the Senior Medical Officer will have responsibility for a number of establishments but the day-to-day routine will be carried out by different people with different backgrounds and that is a potential cause of conflict.

1115. Who should advise the Board of Visitors over whether a prisoner is medically fit for adjudication? If you had that distinction, which one?

(Mrs *Wainwright.)* That is not one we have considered, I must admit.

(Dr *Morgan.)* It has to be the doctor who is working clearly for the patient's interest, the prisoner's interest. If he is not working for the prisoner's interest he is giving himself an ethical problem, so I would have thought clearly somebody who is working on the prisoner's behalf, just the same as you decide elsewhere outside in courts on fit to plead or not fit to plead.

1116. How about preparing a psychiatric report?

[Mr Kennedy *Contd.*]

*(*Dr *Morgan.)* This will be done in a sense by the Prison Medical Officer. That would certainly be done again by a person working not against the prisoner at all but who was there to draw up a clear-cut assessment of the individual prisoner's position and problem.

1117. So you do see, even under the structure you prefer, a need for full-time Medical Officers?

*(*Dr *Morgan.)* Surely.

Mr Galley

1118. You refer in your submission to confidentiality and you say that within the Prison Medical Service confidentiality is a term more used to defend secrecy. Would you like to expand on that?

*(*Mrs *Wainwright.)* There have been instances where it has been very difficult for members of Boards to get information about the type of treatment that is being given, or the number of people who need treatment. Various things can be covered by the term medical confidentiality. You *can* fight your way through it, but we sometimes have to fight quite hard for information. It depends very much on the personality of the doctors involved and their relationship with the Board of Visitors.

1119. Is the problem the Official Secrets Act or ethical confidentiality within the medical profession?

*(*Mrs *Wainwright.)* I do not think it is either. I think it is a form of self-defence in certain instances.

*(*Dr *Morgan.)* The other members of this panel with myself have occasionally been obstructed when they have taken questions through to the Medical Officer and have not been allowed to see or discuss what treatment has been given or might be changed. I have not encountered that problem, perhaps because of my own background, but others have had this difficulty. You do touch on this point of the Official Secrets Act because, if some people are not sure about treatments being given, they want to go and talk with their own GP or friends down the road without giving details of the name; but sometimes they will naturally chew over what has happened to a certain person and the treatment they received. There we are mindful of the Official Secrets Act relating to that part of the question.

Mr Winterton

1120. We have had evidence from w nesses who said that the existence of Official Secrets Act has actually beer deterrent, an inhibition, to them in carry out their work. Can I ask you whether existence of the Official Secrets Act, a stands, is any inhibition to you in carry out the work which you do?

*(*Mrs *Hartog.)* Not at all.

*(*Mrs *Wainwright.)* No.

*(*Dr *Morgan.)* No.

Sir David Price

1121. You suggest in your paper that some prisons the hospital is seen by offic and prisoners as a "step up"—your phr —"in the disciplinary procedure from segregation unit." Can you expand on t and tell us how widespread is this attitu

*(*Mrs *Wainwright.)* I cannot answer question how widespread it is—I do n know. It was a comment which came fr Ashford Remand Centre where I und stand that the protected cells for disrupt inmates are situated in the hospital. though in theory they are supposed to be inmates who are mentally ill or bei assessed as possibly mentally ill, in f there is same suspicion amongst so members of the Board that they are us simply as a more extreme form of punis ment.

1122. For disruptive inmates?

*(*Mrs *Wainwright.)* Yes.

*(*Dr *Morgan.)* In some senses a hospital seen as a soft option.

1123. I would have thought that was t more normal view.

*(*Dr *Morgan.)* It goes both ways.

*(*Mrs *Wainwright.)* It always is, other th those particular cells.

*(*Dr *Morgan.)* Most see it as a soft opti but occasionally it can be seen the oth way.

1124. You mentioned just now the me tally ill, can I take you to the top of page of your evidence where you say: "With t present trend to close down hospitals for t mentally ill and mentally handicapped, a increasing number of people needing t asylum that those institutions offered a being received in prison". This to us is particularly interesting statement becau we did a study last year into the cons

ir David Price *Contd.*]

ience of the closure of long-stay mentally ndicapped and mentally ill hospitals, and wondered if you could expand on this? or instance, have you any evidence that urts are sending mentally ill or mentally ndicapped people to prisons because they not know any other way of getting them, it were, out of circulation when their haviour has been disruptive or anti-cial?

*(*Dr *Morgan.)* This is a question where ere are borderlines. If you can clearly say nentally ill" and everybody knows what is eant by that, and if you can clearly say nentally sub-normal" and everybody is greed on that criterion, you can usually get em placed. It is the borderline people who e disruptive and may be on the edge of ing mentally handicapped; the people ho are not mentally ill in the technical nse with loss of internal controls but those ho are mentally disturbed or disabled in a ay that is often seen in female prisons, that where there is the difficulty. This can be a ry turbulent group which district hospi-ls, with their tender population of sensi-ve, depressive, anxious, phobic people, do ot want and their psychiatrists do not ant. They can use the Mental Health Act, r not use it, to resist taking them, and do sist taking them.

1125. Would we conclude that you have feeling there should be some form of sylum, protective asylum, which does not ist at the moment somewhere in our stem, on the boundary between the Prison ervice and the secure units in the NHS?

*(*Dr *Morgan.)* I am sure there needs to be oth; a prison which is an asylum for some, nd mental hospitals which have asylum hos towards some of their patients. I do ot think they should all necessarily be oing back to the old asylum in the mental ospitals; I do not think they should all be n prisons. I think there are places for both. ome need containment to be easily man-ged, some need the security of a mental ospital and would subsequently have no riminal problems at all.

Mr Winterton

1126. What about schizophrenics? They ave been highlighted in some television rogrammes recently, the violent schizo-hrenics, the more acute ones. It is these eople we have found, from our visits to risons, who are now coming into prisons ecause they have been discharged into the ommunity, there are inadequate facilities in the community, they have committed some sort of anti-social offence which has resulted in them going to court, and then they sadly go to prison. Do you feel there is a particular problem with schizophrenics?

*(*Dr *Morgan.)* I would not say over and above some of the mentally disturbed people, but one has to include the schizophrenic into this, not with the acute symptoms but the burnt-out ones still with much disorder to their personality. This problem is going to be greater in the light of a recent court judgment in terms of one not being able to require people to be present for treatment for one night so they can come off drugs, so they will get worse. This court decision was only a few months ago.

1127. Where would you deal with them? In a prison hospital? Or would you prefer to see a hospital or refuge, as my colleague, Sir David Price said, an asylum; refuge, psychiatric hospital? Is that the most suitable place for them to be dealt with, giving refuge and asylum?

*(*Dr *Morgan.)* I would hope most could be treated in mental hospital. I say "most", one can clearly, with the new provision of the 1983 Mental Health Act and the remand in hospital they are given, see whether the person is containable, and rehabilitation from that setting is by far the preferred way. There will be one or two schizophrenics who are also criminal, it does not totally divide as if there is no such thing as a bad schizophrenic; there will be a few who can be incredibly disruptive.

1128. Do you say they committed their offence because of their mental illness rather than from a criminal intent?

*(*Dr *Morgan.)* If you can see the criminal action follows on from their symptoms—I had better not name names but I can think of a schizophrenic murderer who stabbed a titled gentleman because he had a hereditary title instead of a hereditary disease. That followed on from the prisoner's illogical thinking to an attempted murder. Theft and burglary to secure funds cannot be linked directly to the schizophrenic illness but that is the sort of criminal a psychiatric hospital is not going to want, particularly when he steals from other patients.

Sir David Price

1129. Another aspect of this is that violent prisoners are labelled as psychotic. You suggest some training in human relations should be given and you recommend the DHSS provide "secure accommodation

[Sir David Price *Contd.*]

with a therapeutic regime . . . for all violent prisoners." Can you tell us more precisely what you have in mind, which ties up with what we were talking about just now?

*(*Dr *Morgan.)* We had a little discussion between ouselves as to whether it meant all violent prisoners who are mentally disturbed. This does not quite spell it out and I said this should have read "violent and mentally disturbed" because there are some people who will be violent not for the sake of it but some warp in their fabric. Even with people who have been in Barlinnie, violent prisoners who have written books, there are those poeple who can improve if the humanitarian aspect, as is suggested at Grendon, is right for them. We comment on the need for Grendon to be bigger and to take more people, or for there to be more Grendons or people trained according to the Grendon pattern, so the handling and confidence of Prison Officers allows these people to be contained in a different way and therefore in an improved way and with less incidents. We also note that the incidents go up when the numbers go up above the certified norm; bring it down and the incidents drop.

*(*Mrs *Wainwright.)* We are also concerned about the present method of handling many violent prisoners who may be not technically mentally ill. The whole management of prisoners and the regime they live under can lead to a great deal of aggression, and these people are going into the community and we are concerned there should be a socialisation of such men, so when they go out they are able to cope in the outside world.

Chairman: But you need to have better conditions in the old prisons, do you not, in order to achieve that?

Sir David Price

1130. Can you not go even more generally. I do not want to lead you too far away from the particular point. Reformation used to be one of the classical elements in any penal system. I think you are just putting a new interpretation of it in terms of people who probably need even more reformation than the generality.

*(*Mrs *Wainwright.)* I suppose reformation has been dropped because we are becoming more cynical and recognising that prison is not the place where that really happens.

Chairman: It is so overcrowded you cannot do anything.

Mr Winterton

1131. In your evidence you make a number of recommendations, and one of these recommendations is that pre-release hostels and after-care arrangements be set up for those who have been in prison. Sir David Price has just referred to therapeutic units. Can you actually expand on this particular recommendation which I think is interesting?

*(*Dr *Morgan.)* We are talking not necessarily for the inadequates but thinking in particular for those who within the ordinary prison system may indeed have had all their decisions taken for them and may not have been steered towards taking simple decisions for themselves. The pattern in psychiatric units is to encourage people, if they have been recluses, to begin to take decisions for themselves, even deciding how much they should spend and what pair of shoes they should buy. But if one has these people one needs to steer them towards release from prison, but they are going to need continuing care and encouragement after that point. I am encouraged because just outside Norwich there are three families of prison officers who are selling up their houses and are taking over what used to be a remand centre or, I think, approved school and they aim to take 20 people whom they have known in prison and place them and look after them with three families running it. This is very much in a sense putting into practice what is suggested here.

Chairman

1132. Who is providing the resources for that?

*(*Dr *Morgan.)* The prison officers by selling up their homes and the DHSS by funding with fairly substantial weekly payments for these people, because there are special payments which can be obtained. They have worked their accounts out. I think this can be done.

Mr Winterton

1133. Could you indicate whether you think this is an example that is already in existence and whether or not it could be repeated in other areas of the country?

*(*Dr *Morgan.)* We hope this is going to come into existence. They still have to get over the local population saying "Not in my backyard". If they get over that they think they can establish it within the next two months.

[Mr Winterton *Contd.*]

1134. Doctor, you as a psychiatrist and as a member of the Board of Visitors yourself would go to a public meeting and say "I would recommend that you tolerate these people, there will be no problem, I know them"? Would you be prepared to do that?

(Dr *Morgan.)* Yes, if I had a say in the selection. But the prison officers do have a say in the selection. They are being very careful over the selection. It is the same with any rehabilitation of the mentally handicapped into local homes; you have to start very gently and select very carefully.

(Mrs *Wainwright.)* I thoroughly endorse that. I would also like to add that special units exist within the Prison Service already as at Glen Parva and Wormwood Scrubs, for example, where they are treating particular inmates who have certain difficulties. They have been very concerned in the past about the total lack of any follow-up and they are very anxious that there should be some means of easing people out into the community.

Mr Winterton: Could I move on to something close to all of us, our stomachs? We understand that members of the Board of Visitors are required to inspect the food given to inmates in prisons at frequent intervals. Do you think the food people get in prison is sufficiently nourishing, particularly within the Prison Medical Service, and are you concerned that many prisoners apparently—I think we would perhaps view this with some personal experience from our visits—are slightly overweight?

Chairman: More than slightly, I would say.

Mr Winterton

1135. I am always moderate in my language and measured in my tone!

(Mrs *Wainwright.)* I would have thought the overweight problem also reflects the fact that they have very little exercise.

Chairman: Three large meals a day with bread, potatoes and stodge.

Mr Winterton

1136. I am asking our witnesses, not you, Madam Chairman.

(Mrs *Wainwright.)* Madam Chairman has said it for us. On the whole I must admit I find it difficult to be very critical of prison food. I was at one stage spending a great deal of time visiting somebody in hospital, then going into the prison, backwards and forwards, and finding the prison food was invariably the better; but that does not always follow for special diets which can get very tedious. I do not think they are bad, they just get tedious and repetitive. Most of the complaints we get at the Scrubs would be from vegetarians and vegans who do not always get what they would consider adequate for a vegetarian or vegan diet. That is a problem as much due to cost limits as anything, the repetitiveness of it.

1137. Could I ask you to deal with the question I specifically put: are the meals sufficiently nourishing? That is important.

(Dr *Morgan.)* Undoubtedly so. There is almost nobody who loses weight unless they—

Chairman: On the contrary, they put weight on.

Mr Winterton

1138. Nourishing is not just putting on weight, it is adequate vitamins, protein etc.

(Dr *Morgan.)* They have the undoubted blessing of always having margarine and never butter.

Chairman

1139. They should not eat butter.

(Mrs *Hartog.)* May I just add that there is a new dietary schedule due to come in, I believe, in April which has changed the weekly amounts of different foods slightly. It has increased the amount of fibre, I think, and reduced the amount of protein overall. I think it has improved the diet. I do not know if I could add that the women in our establishment continually complain about the food, and that is about the chips and stodge which the boys in fact appreciate. It is not acceptable to the women and they would much appreciate an increased amount of fruit and vegetables in their diet. I think the new diet includes two pieces of fruit a week, rather than previously the one. They are now going to be allowed brown bread. I do think further investigation could be made on that point.

Mr Winterton

1140. What about food brought into prison?

(Mrs *Hartog.)* For remand prisoners you mean?

1141. Yes, particularly. I understood certain things did come into prison, am I right?

(Mrs *Hartog.)* Oh, yes. Remand prisoners are entitled to have food brought in.

[Mr Winterton *Contd.*]

1142. Fruit and anything can be brought in?

*(*Mrs *Hartog.)* Yes, it can. I do not know whether it is just a local ruling or whether it is in standing orders, but it is only the amount that can be eaten before it becomes perishable.

1143. Could I ask the doctor and then our laymen to come in on the matter of being overweight? Is it due to lack of exercise?

*(*Dr *Morgan.)* There is a lot of concern about lack of exercise, particularly in local prisons with the number of officers who are taken off on court duties. Particularly people in the hospital at Norwich cannot get the exercise and that therefore increases the seclusion of people who need physical exercise, so that they suffer a great deal. But then one is told, if they gave everybody their exercise in the hospital there separate from the other people with whom they could not mix, it would be six hours of an officer's time to get people having their exercise through the day; they just cannot do this. It is a tremendous drawback. It builds up tensions as well as adding to isolation and seclusion; that is not good for health.

Chairman

1144. What do your members from their experience think are the most serious deficiencies in the medical services for prisoners?

*(*Dr *Morgan.)* I think, in spite of the best attempts by the nursing staff, it is the lack of real quality training for the nursing staff. They try to do their best but they are not sophisticated in psychiatric handling of some of the problems. Therefore, they are not able to handle groups of people with borderline emotional problems. Increase their training—which is what they themselves tell us they want—and that would help a great deal. It would also help them, if they left the Prison Service, to go for a qualification to take to psychiatric units outside who are now scared of taking tough patients. If you have people who can take a qualification out from the prisons, where they have done their training, that will mean the district general hospital will take patients rather than leave them in the prisons. There is a tremendous fertilisation which can come about if this can be achieved.

1145. What about women's prisons. What do you think are the major problems there, on the medical side?

*(*Mrs *Hartog.)* There are far fewer women in prison, therefore far fewer establishments. I think there is a higher proportion of disturbed women in prison and, on everybody's reckoning, a lot of those women should not be in prison.

Mr Winterton

1146. Where should they be?

*(*Mrs *Hartog.)* Mental hospitals or—

1147. A secure unit?

*(*Mrs *Hartog.)* Only for some, but for others this refuge Sir David was talking on Mr Winterton: A psychiatric hospital really?

Sir David Price

1148. Well, a little one.

*(*Mrs *Hartog.)* We do have a lot of people who do not come under the terms of the Mental Health Act but do present acute behavioural problems for a very long time and nobody knows what to do with them.

*(*Mrs *Wainwright.)* One of the things which inmates often see as a great disadvantage is the inability to have their own medication with them. I am thinking of people with a heart condition who perhaps are normally expected to carry around certain number of pills with them. These sort of things become very difficult. If it is really dangerous, then they always are allowed to carry them around, but it is the man who is nervous and who feels more at ease when he has got them with him but who is not allowed to, who is the problem. Medication for colds and things, which any one of us would buy for ourselves in the chemist, is not allowed.

*(*Dr *Morgan.)* Another problem is that because the Prison Medical Service is not part of the NHS and DHSS, they do not get these DHSS publications on AIDS.

Chairman

1149. Don't they?

*(*Dr *Morgan.)* No, they go through the Health Service and I get copies and give them to the Prison Medical Officers or send them by post. But the prison is almost on the front line of some of these problems and they do not get the DHSS publications. They may get their own but they are not getting some of these DHSS publications. It is a strange problem which arises from this division.

1150. We will raise this with the CMO. We are hoping to meet him soon.

[Chairman *Contd.*]

*(*Mrs *Wainwright.)* There are all sorts of divisions—

*(*Dr *Morgan.)* —and anomalies.

Mr Winterton

1151. You have yourself no anxiety about the way that the Prison Medical Service will deal with AIDS? We have seen Dr Kilgour who gave us a publication, "Exposure", on how they intend and are seeking to handle this grave problem of AIDS. You will have read that, no doubt.

*(*Dr *Morgan.)* There is anxiety and we are doing our utmost to allay that and see it in its correct perspective. The Senior Nursing Officer at Norwich has drafted his own code but is grateful for whatever documentation I have been able to supply to him.

1152. Nothing has come through from Dr Kilgour?

*(*Dr *Morgan.)* Yes, but the DHSS is sending their own publications out as well but they are not on their circulation list.

Mr Winterton

1153. The Prison Medical Service circulates guidance, is it not as good as the DHSS guidance?

*(*Dr *Morgan.)* They do not have the knowledge of the immunologists and all the other specialists, and virolgists, which is all contained within the Health Service documents.

Chairman

1154. What about the system of remanding people in custody for psychiatric reports, do you have any views on that?

*(*Dr *Morgan.)* So far I do not think enough use is made of the referrals to psychiatric units. I think it has built up and I very much like the approach of that. It has to be done in the prison and normally there is a good liaison, but there is always the question as to how much collusion exists between the defence and prosecution and how much there may be an agreed statement. I find it difficult to act on one side or the other—I have got to know the staff in my local prison very well, but that is my own problem of wearing two hats. I think it usually works well but I would like to see more use of the 1983 Mental Health Act provisions.

*(*Mrs *Wainwright.)* I agree with that last comment.

Chairman: That concludes our questions to you. Thank you very much indeed for your help.

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HOUSE OF COMMONS

SOCIAL SERVICES COMMITTEE

Session 1985–86

PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

Wednesday 19 March 1986

Department of Health and Social Security

Dr R M Oliver, Dr L J F Warnants
Mr J Tait and Mr E B McGinnis

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WEDNESDAY 19 MARCH 1986

Members present:

Mrs Renée Short, in the Chair

Mr Tony Favell
Mr Charles Kennedy
Mr Terry Patchett
Sir David Price
Mr Nicholas Winterton

Memorandum submitted by the Department of Health and Social Security

THE PRISON MEDICAL SERVICE AND THE NHS

Introduction

1. The Committee has already received evidence, written and oral, as to the role of the Prison Medical Service (PMS) (which is not restricted to the care of individual prisoners), its relationship with the Prison Service as a whole, its composition and terms of service, and the extent of the wider contribution through the PMS to the health care of prisoners. There are close links between the DHSS and the Home Office at senior professional level, and these have been strengthened. Ministerial responsibility for the PMS, however, rests with the Home Secretary. Local arrangements are in general made between the PMS and the relevant Health Authority or Family Practitioner Committee, and with individual professionals. Where general practitioners provide a service to prisoners, they do so on the basis of individual contracts with the Home Office for their professional services, and not as GPs for patients on their practice lists. The DHSS does not therefore wish to express any policy view on responsibility for the Prison Medical Service or to add to the basic factual material already provided to the Committee.

2. This memorandum relates mainly to England. It deals with the role of the DHSS; with NHS management and related developments relevant to any consideration of possible changes in the management of the Prison Medical Service; and with Health and Social Services concerns which are relevant as background to the Committee's inquiry. As requested, it deals more extensively with mental health issues, including the implications of the 1983 Mental Health Act, the development of the regional secure unit programme and other secure provision, and with the role of Special Hospitals.

3. Three Annexes deal with: (Annex A) Key provisions of the Mental Health Act and Mental Health Act statistics; (Annex B) The Regional Secure Unit Programme; (Annex C) The Special Hospitals Service selection criteria and procedures.

DHSS Responsibilities in Relation to the Prison Medical Service

4. The Chief Medical Officer has formal responsibilities as CMO to the Home Office and thus to the Prison Medical Service. There is close liaison between the Prison Medical Service and the medical staff of the Medical Mental Health Division in DHSS. This liaison covers such matters as education and training, appointments, professional practice, casework, liaison with professional bodies and central guidance on specific health matters. Dr Kilgour meets regularly with the CMO at his Heads of Medical Divisions meetings —when medical developments, both general and particular, in the NHS and elsewhere, are discussed. The CMO, with Dr Kilgour, has helped to pave the way for a joint initiative of the Royal Colleges of Physicians, Psychiatrists and General Practitioners, and the Faculties of Occupational and Community Medicine, in establishing an advisory group on training and standards of medical practice in the Prison Medical Service.

The cost of printing and publishing these Minutes of Evidence is estimated by Her Majesty's Stationery Office at £2,592.

5. The Home Office recognise the Chief Nursing Officer as being available to provic professional advice, support and counsel to the Head of Nursing Services (Mr P Barker) an through him to the Prison Nursing Service. She also meets, as necessary, with Dr Kilgou and Mr Barker. The Principal Nursing Officer (Mental Health etc) is the main point contact on a day to day basis, which includes attendance at the Home Office Hospit Officers/Nurses Education Committee. Advice is given on appointments, profession practice, liaison with professional bodies and the interpretation of policy on health matte as they affect nursing care. Guidance on local liaison with the NHS on, for exampl specialist nursing support for pregnant women prisoners and prisoners with babies, and c care of drug misusers, is also given.

General Management in the NHS

6. As the Committee knows, the "general Management" function is being introduce into the National Health Service. Within the Department, a Management Board has bee set up to co-ordinate and manage the implementation of central policy and guidance c behalf of the Secretary of State. General Managers have been appointed at Regional an District level, and by June 1986 all general managers at unit (eg hospital) level will hav been appointed. At the same time, Family Practitioner Committees have been made ful autonomous of District Health Authorities and are accountable directly to DHSS Minister

7. Accountability, with maximum devolution of decision making to local level, achieved through review processes. Ministers hold Regional Health Authority Chairme and their officers to account for specific objectives, and in turn Regional Chairmen ho District Health Authority Chairmen to account. At District level unit general manage account for their performance to the District general manager. The specified objectiv include those concerned with the development of integrated comprehensive local networl of services for mentally handicapped and mentally ill people, and with the co-operatic with social services departments necessary to achieve this. The thrust and direction community care policies is discussed in various of the Committee's Reports an Government Responses including Cmnd 9674 (Community Care with special reference adult mentally ill and mentally handicapped people).

Implications of General Management for PMS/DHSS Relationships

8. This firmer and clearer structure of accountable management in the NHS, and the loc autonomy within a framework of agreed tasks and priorities it entails, would clearly not re easily with the management and running of a service which required a high degree national consistency. Conversely, accountability for the PMS within the NHS wou distance prison management from the resource planning and operation of its medic service.

9. If, notwithstanding these factors, "integration" were being considered, there might b three possible models:—

9.1 *Full local integration (Management by District Health Authorities)*

In addition to the difficulties referred to above, problems might well arise from nation and regional NHS resource allocation priorities; eg transferring resources from ove provided to under-provided Regions and Districts, and from the acute hospital servic to priority care groups such as elderly people. If financial resources were transferred to th "host" District, those prisons in remote rural areas would be relatively over-provided comparison with services to the population as a whole in that District, and the resourc allocated would be in danger of being pruned to speed general developments in th District. Conversely, prisons in inner city areas could not be isolated from the effects general re-allocation policies to the suburbs and surrounding new towns.

9.2 *Earmarked grants to host DHAs*

Such an approach, while "guaranteeing" the resources of the PMS, would n necessarily tackle its alleged isolation. It would remain isolated from mainstream NH planning both in resource and manpower terms, and, to the extent that "stigma" associated with the nature of the work, and the networks of relationships of the staff, th management change would not remove the stigma.

9.3 *Central Management*

The PMS could, perhaps, be run either by DHSS, a "special health authority" (SHA), or one of the 14 Regional Health Authorities as DHSS's agent. However, running the PMS through the DHSS or a newly created SHA would only constitute a cosmetic integration with the NHS. Problems of integration and joint planning at local level would still need to be tackled, and most of the difficulties inherent in the present arrangements would remain. Similar problems would exist if one of the existing RHAs acted as agent on a national basis for PMS management. Such a system has worked well for support services, where the customer RHAs have a service need for the managed function (such as contracts for the supply of artificial limbs; hearing aids; the London Ambulance Service etc). But where the managed function might easily remain isolated in customer RHAs, planning, integration would again be merely cosmetic. At the same time the ultimate accountability of the Secretary of State for Social Services would have to be reconciled with the accountability for the Prison Service of the Home Secretary.

10. The Committee are aware of the links that have been suggested between the Special Hospitals Service and the PMS, or between the latter and "forensic" services more generally. However, wider forensic services are inextricably and increasingly entwined with the more general mental health services, and the PMS is not concerned exclusively with psychiatry. The Special Hospitals deal with one relatively small and "special" part of the concerns of the forensic and other mental health services.

LINKS WITH THE NHS

11. If the objectives of any changes envisaged were closer links with the NHS in terms of training, experience, consultation, etc, this might more directly and more readily be achieved by improved partnership than by absorption which could be hard to achieve and carry side effects that were not intended.

12. There are already signs of progress, as other evidence has brought out, particularly in the placement of mentally abnormal offenders and "difficult to place" patients.

(i) DHSS Ministers have particularly emphasised NHS responsibilities in this area and officials have had meetings with each RHA which included staff from NHS, Prison Medical Service, Special Hospitals and RSUs on the "Difficult to Place" patient, with a final review by Ministers and a letter from Ministers to RHA Chairmen.

(ii) Prison Medical Officers can look for support to some 40 consultant forensic psychiatrists, as against only 12 as recently as 1979, and some 30 Special Hospital consultants.

(iii) The involvement of both Regional Forensic Advisers, and, under the Mental Health Act requirements, Regional Medical Officers in the placement of the more difficult patients (29 Section 39 referrals in 1984) has helped to strengthen the role of the NHS in catering for those mentally disordered people who have fallen foul of the law and who come within the scope of the Mental Health Act.

(iv) The development of the Regional Secure Unit programme has provided an increased number of "secure" places.

(v) There have been special interest meetings organised by DHSS and others at which the Prison Medical Service has been present.

(vi) There are training opportunities in the Special Hospitals and RSUs for prison medical officers and nursing staff.

13. The DHSS will continue to explore with the Home Office, in the light of changes both in the Prison Medical Service and in the NHS, and taking account of the Committee's findings, what further links might be developed. These discussions will be co-ordinated with an Advisory Group that is being set up by the Royal Colleges and others.

THE 1983 MENTAL HEALTH ACT

14. The 1983 Act followed in the steps of the 1959 Mental Health Act, and produced a

broad and much debated consensus of many interests anxious to incorporate as much a appropriate of the previous 25 years experience into legislation. The Act supplements rath than replaces wider health legislation; and it is concerned in particular with those patien who need to be detained in hospital for treatment. It defines mental disorder (excludin from that definition alcohol, drug and sex problems on their own) and the criteria that mu be met for detention; enlarges patients' rights to review of their detention orders, b increasing the frequency of access to mental health review tribunals and enlarging th powers of the tribunals; and introduces independent consent to treatment procedures, wi various degrees of safeguards in relationship to different forms of treatment. Oth provisions deal with transfers from prison to hospital; and allow the courts to remand person in hospital for assessment, for interim hospital treatment where their long-ter treatment needs require further investigation and for hospital treatment, with or without restriction order, instead of a prison sentence.

15. The Act established the Mental Health Act Commission with particular responsibil ties for overseeing the arrangements for the admission and treatment of detained patient but also responsible for securing second opinions on treatment, and for drafting the Code Practice on admissions and treatment that the Secretary of State has to issue f consultation and in due course lay before Parliament. The Commission notes in its fir Biennial Report that it will be briefing itself on mentally disordered people in prison ar their treatment.

Placement Difficulties for Mentally Disturbed People

16. The view has been expressed that the Mental Health Act and community care polici together make it more difficult to secure treatment for some people, and more likely th some mentally disordered people will be put or kept in prison rather than getting a hospit place. Perceptions on this vary among both theorists and practitioners. The Mental Heal Act has set up more stringent criteria for detention, particularly with reference treatability, and civil rights considerations have led to the need to watch carefully that r person is detained or continues to be detained by mental health law, who does not me these criteria. However, the courts have greater flexibility in testing the appropriateness of hospital placement as experience and practice with the new powers develops, and can no require the help of the Regional Health Authority in finding a place in the few instanc where normal channels of communication have proved inadequate. The thrust of the A and of community care policies is not to make treatment more difficult, but to achieve better assessment of treatment needs, readier access to treatment which reaches out people where they are—without institutionalising them unnecessarily—and treatme regimes which reflect modern good practice agreed between members of a mult disciplinary team and involving the patient himself as a responsible adult to the extent th he is capable of this.

17. Hospital closures are following a long period of natural run-down, and are planned follow not to precede the establishment of alternatives; but the changes are not a matter community replacing hospital, or generalist replacing specialist services. As well as th substantial increase in the numbers of community psychiatric nurses, who are now contact with some 80,000 patients at any one time, and the establishment of a core approved social workers trained in the concepts and rules of the new Act, the developme of day hospitals and mental health centres, hospital hostels, and psychiatric units in Distri General Hospitals, means readier access to specialist services.

18. Many of the acknowledged difficulties are not created by either the Mental Health A or community care policies, and they centre around certain groups of people. The mo problematic people tend to remain problematic under any system.

(a) One concern is how best to deal with "socially inadequate" or socially vulnerab and rootless people for whom neither prison nor hospital is the right place but who c need some form of help and support.

(b) There is a group of people with personality disorders and often very seve behaviour problems who are not detainable under the Act, and for whom neither pris nor hospital can do very much.

(c) There are, of course, psychopaths and sociopaths whose diagnosis, and treatability and detainability, are subject to professional debate, some moving from prison to hospital and back again.

(d) Some mentally handicapped people who are also mentally ill or disturbed for some other reason are difficult to place, with a lack of clearly appropriate long-term facilities in the NHS. A DHSS working group is looking at this.

19. On provision for drug misusers in prison and on release, attention is drawn to paras 45–55 of the Government Response to the Fourth Report from the Social Services Committee, Session 1984–85 (Cmnd 9685). With regard to primary health care for homeless people, the Committee's attention is drawn to a pilot project sponsored by DHSS in London, with units in Tower Hamlets and Camden. A multidisciplinary team will seek to make contact with homeless people where they congregate, to assess their special needs (eg alcoholism), and as far as possible to secure their admission to a general practice list.

20. Within the Prison Service there are at any one time about 100 sentenced prisoners who the Prison Medical Officer considers could be transferred under the powers of the Mental Health Act to hospital. It has already been pointed out that within the prison population there is a far larger number of disordered, disturbed people who are not detainable under the Act, and will contain people from the groups described above, who present problems and require some form of special management within the Prison Service. (Dr Kilgour has discussed these groups.)

Regional Secure Units

21. Details of current provision are given in Annex B. The permanent secure unit network is still incomplete, but 10 out of 14 NHS Regions now have a permanent unit designed to provide assessment and treatment for mentally disordered people who need security at a level less than that available in the Special Hospitals Service and greater than that normally available through locked wards in psychiatric hospitals. They are designed to provide shorter-term care: that is care for those likely to respond to treatment within two years. Some 500 beds in permanent units have been completed. By the end of 1986–87 the number will be nearly 650. The pattern of provision varies. The West Midlands will provide a large unit of up to 100 beds in Birmingham; South East Thames has a more dispersed service, with a central clinic and four smaller peripheral units; South West Thames is exploring the possibility of a largely dispersed service using identifiable facilities with appropriate staffing in existing hospitals plus a core unit. Building and service evaluations are now in progress. There are in addition some 3–400 places in designated interim secure units—the number of falling as the number of permanent places rises; and roughly 2,000 lockable places elsewhere within the wider service.

The Special Hospitals Service

22. A note on admission criteria is at Annex C. The four Special Hospitals managed by the DHSS cater for some 1,600 patients detainable under the Mental Health Act who "require treatment under conditions of special security on account of their dangerous, violent or criminal propensities". 70 per cent of them are admitted under a Court Order; most of the rest from NHS hospitals. The average time a patient will stay in a Special Hospital is now about seven years, with variations according to the particular condition. (The 1983 Mental Health Act has enabled the MHRTs to discharge restricted patients, as most Special Hospital patients are, but has preserved the Home Secretary's powers in relation to leave and transfer of such patients, and in relation to discharge other than by an MHRT.) The Special Hospitals have close links with those prisons which are in their (broadly defined) catchment area; and prison staff come in for experience while Special Hospital staff visit prisons to assess patients for admission, or to give advice.

February 1986

ANNEX

MENTAL HEALTH ACT 1983

TRANSFERS FROM COURTS OR PRISONS TO HOSPITALS

1. The Act applies only to mentally disordered people—defined as those who suffer fro mental illness, arrested or incomplete development of mind, psychopathic disorder, or ar other disability or disorder of mind. Detention for assessment may be for mental disorder generally defined, but detention for treatment can only be for a specified form of ment disorder—mental illness, mental impairment, severe mental impairment, psychopath disorder. Remands for treatment (unsentenced people) can only be made for mental illne or severe mental impairment. Other orders also cover psychopathic disorder and ment impairment but only "if treatment is likely to alleviate or prevent a deterioration of" t condition. A similar treatability condition applies to transfers from prison to hospital.

2. The provisions of the Act likely to be of most immediate concern to the Committ are:

(a) *Section 35:* The Court can remand an accused person to hospital for a report on h mental condition. The remand can be up to 28 days in the first place, renewable for up an overall total of 12 weeks. There has to be medical evidence suggesting the presence one of the specified forms of mental disorder. This power provides an alternative remand in custody for a report, or remand on bail with a condition of residing in hospit

(b) *Section 36:* The Court can remand an accused person to hospital for treatment. this case two doctors need to provide evidence of mental illness or severe ment impairment. The time limits are as for Section 35. This Section provides an alternative the emergency transfer to hospital of an unsentenced prisoner.

(c) *Section 37:* The Court may send a convicted person to hospital or place him und guardianship, provided that two doctors provide evidence of specific mental disorder. N period of detention has to be specified. (A magistrate's court satisfied that a person cou be convicted can make a hospital or guardianship order without convicting him.)

(d) *Section 38:* The Court can make an interim hospital order on the evidence of tw doctors that there is a specific form of mental disorder and where they want to te whether hospital is the appropriate place for a mentally disordered offender. These orde can be made for up to 12 weeks, renewable up to a maximum overall period of s months.

(e) *Section 39:* A Court considering making a hospital order can require a Region Health Authority to furnish information about an appropriate hospital in that Region elsewhere. (This is essentially a fall-back if the normal arrangements for doctor to doct contact don't work.)

(f) *Sections 41–4:* These sections deal with various aspects of the Crown Court power impose restrictions, with or without limit of time, on a person being made subject to hospital order. These restrictions block the normal release powers of managers ar responsible medical officers, and require the Home Secretary's consent to vario easements in the hospital regime. But a tribunal chaired by a judge can still discharge patient despite the restriction.

(g) *Section 46:* Life sentence patients ordered to be kept in custody during H Majesty's pleasure are automatically restricted.

(h) *Section 47:* The Home Secretary can transfer to hospital a convicted mental disordered prisoner needing hospital treatment who meets the requirements for detentio under the Mental Health Act.

(i) *Section 48:* Makes corresponding provision in respect of other prisoners, eg those c remand, in urgent need of treatment.

(j) *Section 49:* Transferred patients may be subject to restrictions. Under Section 5 the Home Secretary can send such a person back to prison when his treatment is finishe if his sentence has not expired.

3. The latest complete set of figures relating to remands for assessment, remands f treatment, interim and other hospital orders, and transfers from prison relate to 198 These are set out below.

TABLE 1

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

MENTAL ILLNESS and MENTAL HANDICAP HOSPITALS and UNITS in ENGLAND
(excluding Special Hospitals)
SUMMARY of the Legal Status of Resident Patients at 31 December 1984

LEGAL STATUS		RESIDENT PATIENTS												
	Detained under	Mental Illness		Psycho pathic Disorder		Mental Impair-ment		Severe Mental Impair-ment		Other		Total		
	MH Act 1983, Section:	M	F	M	F	M	F	M	F	M	F	M	F	Patients
	2 Assessment	345	459		3	2	4	1	1	5	6	353	473	826
	4 Emergency Assessment	24	25									24	25	49
	3 Treatment	975	1073	5	12	56	26	38	29	5	4	1079	1144	2223
	5(2) Already in Hospital	25	27									25	27	52
	35 Remand for Report	9	2		1	1		1		1		12	3	15
	36 Remand for Treatment	4										4		4
Hospital orders	37* (with section 41 restrictions)	276	41	42	4	76	6	20		3	1	417	52	469
	37* (without section 41 restrictions)	296	60	9	8	48	8	13	1	1		367	77	444
	37(4), 44	6					1	1				7	1	8
	38 Interim Hospital Order	4	2	1	1							5	3	8
	46 Detained "During Pleasure"	15	3									15	3	18
Transfer from prison	47, 48 (with section 49 restrictions)	33	2	2								35	2	37
	47, 48 (without section 49 restrictions)	9	1							1		10	1	11
	135 136 M.D. person in public place	10	1									10	1	11
	Previous legislation (Fifth schedule)	22	8			5		5	2			32	10	42
	Other sections of MH Act 1983 or other Acts	22	6			6		6		4	1	38	7	45
	Total detained	2075	1710	59	29	194	45	85	33	20	12	2433	1829	4262
	Not detained treated informally											45585	54048	99633
	TOTAL (detained and not detained)											48018	55877	103895

*Excluding Section 37(4)

TABLE 2

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

SPECIAL HOSPITALS

SUMMARY of the Legal Status of Patients Resident in Special Hospitals at 31 December 1984

LEGAL STATUS	RESIDENT PATIENTS												
Detained under	Mental Illness		Psychopathic Disorder		Mental Impairment		Severe Mental Impairment		Other		Total		
MH Act 1983, Section:	M	F	M	F	M	F	M	F	M	F	M	F	Patient
2													
4													
3	108	67	8	5	25	10	28	38			169	120	28
5(2)													
35			1								1		
36													
37* (with section 41 restrictions)	425	47	237	51	75	11	6	1			743	110	85
37* (without section 41 restrictions)	91	16	36	11	19	7	1				147	34	18
37(4), 44													
38													
46	27	8	2		2		2				33	8	4
47, 48 (with section 49 restrictions)	80	9	25	1	4						109	10	11
47, 48 (without section 49 restrictions)	6	1	1		1						8	1	
135													
136													
Previous legislation (Fifth schedule)	8	2	1		3	2	9	20			21	24	4
Other sections of MH Act 1983 or other Acts	63	5	1	2	10	4	7				81	11	9
Total detained	808	155	312	70	139	34	53	59			1312	318	163
Not detained treated informally											3		
TOTAL (detained and not detained)											1315	318	163

*Excluding Section 37(4)

ANNEX B

REGIONAL SECURE UNITS

10 of the 14 Regions now have permanent regional secure units in operation, as follows:

Region	Location	Current Bed Complement	To be completed 1986–87
Northern	St Luke's Hospital, Middlesbrough	30	
Yorkshire	Fieldhead Hospital, Wakefield	48	
Trent	Towers Hospital, Leicester	60	
East Anglian	St Andrews Hospital, Norwich	36	
NW Thames	St Bernards Hospital, Ealing		40
NE Thames	Runwell Hospital, Nr Southend	10	
SE Thames	Bethlem Royal Hospital, and linked units at Bexley, Croydon, Maidstone and Eastbourne[1]	90	
Wessex	Knowle Hospital, Fareham	31	
South Western	Langdon Hospital, Dawlish	30	
West Midlands	Rubery Hill Hospital, Birmingham		100
Mersey	Rainhill Hospital, Prescot	50	
North Western	Prestwich Hospital, Manchester	20[2]	
		493	633

[1] Eastbourne Unit (15 beds) not yet open
[2] Plus 88 bed unit (also at Prestwich Hospital) to open shortly

ANNEX C

Extract from DHSS Memorandum on the Mental Health Act 1983

SPECIAL HOSPITALS

266. Special Hospitals are required to be provided by the Secretary of State for Social Services under Section 4 of the National Health Service Act 1977. There are four special hospitals: Broadmoor, Rampton, Moss Side and Park Lane. They provide the same range of therapeutic services as ordinary psychiatric hospitals but they are intended by virtue of the National Health Service Act 1977 for the treatment of patients who are detainable under the Mental Health Act and who, in the opinion of the Secretary of State, require this treatment under special security because of their dangerous, violent or criminal propensities. The régimes of care and observation are such that they can only be justified when the highest level of security is required and no lesser degree of security would provide a reasonable safeguard to the public.

267. All admissions to special hospitals are determined centrally by the Department of Health and Social Security; formal applications should be made to the DHSS (MHC(2))

Alexander Fleming House, Elephant and Castle, London SE1 6BY. The Department wil usually then arrange for a special hospital consultant to examine and report on the patien where this has not been done in advance. The final decision in all cases rests with th Department, acting on behalf of the Secretary of State, and the applicant will be advised o the outcome.

268. The application should contain a full account of the patient's psychiatric and socia history, together with details of any criminal history and a full description of th circumstances which give rise to the application. It is not sufficient merely to list the charge and/or previous convictions or to summarise behaviour as "aggressive", "assaultive" "dangerous" etc without evidence of the nature of the dangerous behaviour and th circumstances in which it was used. Any references to absconding behaviour should giv details of any incidents and pay particular attention to the amount of planning an determination involved. Supporting documents, such as depositions, can also be helpfu The application should also give reasons why treatment in secure conditions which fall shor of the level of security in a special hospital is considered inappropriate.

269. Special hospital admission is *not generally* considered suitable for patients who:

i. are suffering from severe mental impairment—unless there is a *strong probability* tha the patient will seriously harm staff/other patients, if the opportunity presents;

ii. though exhibiting extreme disruptive or anti-social behaviour in the community c local hospital are unlikely to inflict serious physical injury;

iii. require close observation mainly to prevent self injury—unless this is associated wit a *probability* of violence to others;

iv. require asylum/long term care but for whom lesser conditions of security woul provide adequate protection for the public;

v. would simply benefit from the stability and support of a physically secur régime—unless they also present a risk of serious harm to the public at large;

vi. are under 16 years of age or over 60.

Provision of comprehensive facilities for such patients is the responsibility of regional an district health authorities. Any lack of local provision for difficult to place patients will no usually be accepted as a reason for admission to a special hospital.

270. Where the Department declines to make a special hospital bed available, th referring doctor and, where appropriate, defence solicitors and the courts will be notified o the reasons. It will be for the applicant to take up with the health authority concerned wha suitable arrangements can be made to meet the needs of the patient concerned.

271. The conditions for admission described above will apply equally to patients liable t detention under civil powers, or hospital orders, or interim hospital orders, or remands t hospital for report/treatment and to those transferred from prison by direction of the Hom Secretary.

Examination of Witnesses

Dr R M Oliver, Deputy Chief Medical Officer, Dr L J F Warnants, Senior Medical Office Mr J Tait, Principal Nursing Officer and Mr E B McGinnis, Under Secretary, Ment Health Division, Department of Health and Social Security, called in and examined.

Chairman

1155. We are very grateful to you for agreeing to come and help us with the inquiry, a sort of mopping up exercise in many ways, of matters that we have met during the course of the inquiry and arising out of your own paper. In your paper yo refer to an advisory group on training an standards of medical practice in the Prisc Medical Service, could you tell us somethin more about this? Does it really work nov Has it started to work and what is its remi

[Chairman *Contd.*]

*(*Dr *Oliver.)* I can say something about this committee. It stemmed from an initiative of the Chief Medical Officer in collaboration with the Director of the Prison Medical Service and discussions were held with the Royal College of Physicians and other professional bodies with an interest in this area of medicine with a view to seeking some focal point of professional contact for doctors working in the Prison Medical Service and doctors interested in prison medicine generally. The Royal Colleges are planning to start this sub-committee to form this focal point. The Department of Health will have an observer on the committee. So far as the proceedings of the committee are concerned I do not know at this time whether they have actually undertaken that operation but I think they are still in the throes of negotiating arrangements for the committee but this hopefully will emerge in the very near future.

1156. I take it its remit would spread right across the whole of the Prison Medical Service, would it?

*(*Dr *Oliver.)* It would spread across those aspects which concern the activities of doctors. Obviously the committee will be composed of the medical professional bodies and will be interested in matters relating to prison medicine in general.

1157. What about prison nursing officers?

*(*Dr *Oliver.)* That is a separate issue.

*(*Mr *Tait.)* I think there was a suggestion that there should be talks held with the Royal College of Nursing but as the Royal College of Nursing has few members in the prison nursing service at the present time it might also be appropriate to talk with the Prison Officers Association.

1158. That will be done, that has been agreed has it?

*(*Mr *Tait.)* As I understand it there were to be approaches to the Royal College of Nursing.

Mr Winterton

1159. It is always too long; why is an advisory group not set up straight away, does it take all of that preparation?

*(*Dr *Oliver.)* If I can answer in relation to the medical one. The timing and arrangements for setting up the committee rest with the Royal College of Physicians and the other Royal Colleges concerned, that is a matter that is really for their judgment. There is a necessity to decide with the other Royal Colleges on the procedure, the terms of reference and what their objectives will be. This is a fairly new field for the professional bodies to become involved in, it does take a while to negotiate the exact arrangements. I am sorry I cannot tell you how far they have got with the arrangements.

Chairman

1160. Perhaps you could let us know?

*(*Dr *Oliver.)* I think the Director of the Prison Medical Service might be in a better position to let you know but we can certainly find out.

1161. Do you have any arrangements for regular contacts between the regions and districts, I am talking about the health authorities, and the Principal Medical Officers in each region of the Prison Medical Service?

*(*Dr *Oliver.)* So far as I am aware there are no formal arrangements for this. This is a matter which would rest with the health authorities concerned and, as you say, the Principal Medical Officers of the prisons concerned. This is not a matter we have centrally taken any action about.

1162. Do you think it would be a good idea if there are more contacts between them?

*(*Dr *Oliver.)* I hope there are more contacts and if there are not I think it would be a good idea if there were.

*(*Mr *McGinnis.)* As the Committee will have gathered from previous evidence, one of the most important developments in recent years has been the development of a corps of regional forensic doctors, forensic psychiatrists, and that development has meant there is a natural contact point through common professional interest with the prison doctors. To the extent that the major problem appears as a mental health one, and as regards the medical service there is a natural contact point there and the regional forensic doctors and prison doctors do meet regularly.

1163. If you are planning in any NHS region the provision of secure accommodation or whatever I would have thought it would be advantageous to have contact in the regions?

*(*Mr *McGinnis.)* It is very much so. If I can glance aside at one topic which bears on that, the Hard to Place Exercise we have called it, which was a ministerial initiative.

[Chairman *Contd.*]

It meant that meetings were held at regional level with health authorities and prison authorities were involved in that because they have an interest in the development of that sort of mental health facility.

1164. Have you thought at all of any sort of local liaison committees to co-ordinate the treatment of mentally disordered prisoners so that you have an exchange of views between the NHS and prison medical staff, a discussion as to how that should be organised, treatment and that sort of thing?

*(*Mr *McGinnis.)* This is perhaps one that Dr Warnants might want to come in on. My initial reaction is that you need two things: one, you need an organisational structure within a district which has some part of the prison service in its hands, including a forensic doctor who has contacts with his opposites in the Prison Service; and you need working contacts between doctors in that area: catchment area consultants, and the doctors in the Prison Service. In other words, you need a day-to-day working relationship to make the system, once it is established, work and something more than contact to make sure the system is in place in the first instance.

1165. Do you wish to add anything?

*(*Dr *Warnants.)* Only to say that there is much more forensic work than there are forensic psychiatrists to do it, and most psychiatrists do some forensic work some of the time. Therefore, I would be somewhat wary of formalising the relationship between forensic specialists and prison services for fear that they could quickly become overloaded and perceived or dismissed by the rest of the profession on the basis of, "This is forensic and is nothing to do with me; let it go in that direction." I would be worried about that.

1166. The special interest meetings you refer to in paragraph 12 of your paper have been the formal get-togethers you have mentioned?

*(*Mr *McGinnis.)* Yes, based on common professional interest in what I might call difficult patients.

1167. I gather from your response that you feel there is a shortage of forensic psychiatrists?

*(*Mr *McGinnis.)* In the past there has been a gross shortage, and, as Dr Warnants says, forensic psychiatry is a combination of psychiatric expertise and an understanding of the mental health law which relates, on the whole, to a small minority of mentally ill or handicapped patients. There has not been enough of that expertise in the past; now we have got up to a level of about 40 in post in the NHS the situation is much happier. It is still fair to say that a number of places seeking to enlarge their provision of forensic specialties have not got what they want, but again Dr Warnants keeps a check list of how improvements are taking place.

1168. Which are the areas which have not got the numbers they need or want?

*(*Dr *Warnants.)* It is very difficult to say because health authorities will make their own decisions as to whether or not they will appoint a forensic psychiatrist, and there is the question of supply. Forensic psychiatrists are coming on stream, and the present goal is one forensic psychiatrist per one million population, and we are 15 short in the NHS excluding special hospital forensic staff. The only region I can think of, off the top of my head, which does not have one is Oxford.

1169. We must see what we can do to give some stimulation in that area.

*(*Dr *Oliver.)* Sometimes it is difficult to identify who is a forensic psychiatrist because it is a relatively recently recognised specialty. There are a number of psychiatrists who have expertise in that field but who are not actually described as such. It is perhaps difficult to draw too many conclusions from figures.

Mr Winterton

1170. That shortfall of 15 might not be as important as otherwise would be the case?

*(*Dr *Oliver.)* I think that is probably so. It is terribly difficult to be categorical about it but I suspect it would be an under-statement rather than an over-statement. The numbers are increasing steadily, and there is a proposal that they be increased. There are something like 16 registrars in training now to be forensic psychiatrists.

Chairman

1171. What are the criteria you take into account when you say there are about 40 forensic psychiatrists? How do you identify them?

*(*Dr *Warnants.)* They are appointed by the health authorities.

1172. As forensic psychiatrists?

*(*Dr *Warnants.)* Yes.

[Chairman *Contd.*]

1173. Presumably, they have the qualifications and experience to be so described?
*(*Dr *Warnants.)* That is right.

1174. Are you satisfied about that?
*(*Dr *Warnants.)* Yes.

Sir David Price

1175. To go to a slightly different point, in paragraph 4 you state that the Chief Medical Officer has formal responsibility as Chief Medical Officer to the Home Office and thus to the Prison Medical Service. Can you tell us in slightly more detail what precisely this means?
*(*Dr *Oliver.)* The Chief Medical Officer of the DHSS is also formally the Chief Medical Officer of the Home Office as well as of a number of other government departments. In this capacity he is responsible for offering advice on any medical issue which is or should be the concern of the Home Office, and he is available to give medical advice on any matter put to him by the Home Secretary or the Home Secretary's officials. He has no line management responsibility to the Prison Medical Service. Since he is head of the Medical Civil Service he is obviously concerned with professional standards and with the training and career prospects of all doctors working in the Civil Service, and for these reasons he maintains very close liaison with the Director of the Prison Medical Service and matters of mutual interest are discussed regularly between the medical staff of DHSS and the Director of the Prison Medical Service. I do not know whether that answers you question.

1176. He is a consultant, if I may coin the phrase, to the Home Office rather than being in the position that the Chief Medical Officer has within your own Department?
*(*Dr *Oliver.)* I do not think that is precisely correct. His relationship with the Home Secretary is very similar to his relationship with the Secretary of State for Social Services; he is the Chief Medical Officer to the Home Office.

1177. How does he exercise those responsibilities? I think we have a pretty good idea of how he exercises his responsibilities in the Department?
*(*Dr *Oliver.)* They are very much personally-led responsibilities, although he is supported in that role by the medical staff of the Department of Health. So if there was a mental health issue which he felt the Home Office should be concerned about in relation to the Health Service's field of activities he would either offer advice on his own initiative or respond to a request for advice from the Home Office. The issues may be fairly broad issues of concern, for example immigration would be one.

1178. But in practice which way does it work? Is it the case that his advice is sought by the Home Office, or does he offer advice to the Home Office? He is a very busy man.
*(*Dr *Oliver.)* It would be difficult for me to speak for him, but my impression is that it probably is fairly equal: a number of issues will come to him from the Home Office, and equally in his Chief Medical Officer capacity he will raise certain issues, for example in the field of drug addiction.

1179. What is the exact relationship with Dr Kilgour? Is it *primus inter pares* or simply *inter pares*—just simply colleagues?
*(*Dr *Oliver.)* I think the relationship can best be described as a professional relationship in terms of interest and concern for the activities of a branch of the Medical Civil Service, but the relationship is very similar to that in other branches of the Medical Civil Service which operate on a day to day basis quite independently and are not in any sense in a line management relationship; in other words, they are not directed by the Chief Medical Officer, nor are they directly accountable to him for their activities.

1180. To make it absolutely clear, in no way does your Chief Medical Officer feature in the direct hierarchy between Dr Kilgour and the Home Secretary?
*(*Dr *Oliver.)* That is right.

Mr Winterton

1181. Does this link with the Home Office lead to circulars and memoranda from the DHSS actually going into prison establishments?
*(*Dr *Oliver.)* Not specifically. There may be a departmental circular which would be of relevance to doctors working, for example, in the Prison Medical Service; that would be copied to the Director of the Prison Medical Service.

1182. Lots of circulars that come out of the DHSS may not, as it were, be directly related to the Prison Medical Service but they are concerned with medicine and people's health and people's health in prison is no different from people's health outside prison. Do the flow of guidelines and circu-

[Mr Winterton *Contd.*]

lars which would normally flow from the DHSS go to all hospitals and would they not, therefore, go into the Prison Medical Service and to the prison establishments?

(Dr Oliver.) They would if they are relevant. The distribution is selective.

Sir David Price

1183. That is decided, presumably, by Dr Kilgour and his staff?

(Dr Oliver.) The decision as to whether it is sent to Dr Kilgour will be made in the Department of Health.

1184. Dr Kilgour, having got it, he determines what goes out?

(Dr Oliver.) Except in certain classes of communication. I am thinking of Chief Medical Officer letters which are occasionally directed to all doctors in whatever establishment they may be. These go to them in their private capacities and to their private addresses.

1185. Can we move on to the nursing aspect of the same relationship?

(Mr McGinnis.) I wonder if I might slide in one last point on the medical front? You will have seen in our memorandum that Dr Kilgour does attend the meetings which the CMO has with his divisional heads, the sort of topics which attract circulars of prime importance are likely to be discussed at those meetings. Thus it is not an ad hoc accidental process, the circulars are discussed between them, including Dr Kilgour.

Mr Winterton

1186. I am particularly interested as to the updates, the new ideas that flow from your Department into the DHSS establishments, why there should be any differential between them and the prison establishments because if it is to do with medicine I would have thought wherever people are it should be relevant and those circulars should go out on a more general basis than they apparently do at this moment?

(Mr McGinnis.) I am venturing on to medical ground here but I think a slight distinction needs to be made, perhaps with AIDS as an example: AIDS is of concern to all people working in institutions, whether it is hospitals or prisons and, therefore, literature giving guidance coming from the Department is likely to be of value and will go to those who work in the Prison Medical Service; but the Prison Medical Service having a particular role in a particular place may want to gear the advice to its own institutions and their particular circumstances.

(Dr Oliver.) I entirely agree with what Mr McGinnis has said.

Sir David Price

1187. Can we move on to the nursing aspect? In paragraph 5 you said that the Home Office recognises the Chief Nursing Officer of the DHSS as being available to provide advice, support and counsel to the Head of Nursing Services in the Prison Medical Service, and describe a variety of contacts and items. Do you find this liaison satisfactory, good enough?

(Mr Tait.) Yes.

1188. It is very similar, is it not, to what we were discussing in relation to the CMO?

(Mr Tait.) Yes. I think it is not quite the same as the CMO's role but you did mention acting as consultant to the Home Office and that might be a better description of how Mrs Poole is recognised as being available to consult on matters of professional advice when necessary. Sometimes we may be proactive in information we give to the Head of Nursing and AIDS was just mentioned. We have an officer in the Department who is an expert on the nursing of people with AIDS and when we were putting together our advice we gave that to the Prison Service Head of Nursing as a form of guidance that might be useful to him. The Head of Nursing is invited to my meeting with the Chief Nursing Officer of Special Hospitals. We try and involve him and keep him up to date on what is happening with regard to nursing in Special Hospitals and he can share that with his colleagues. We try to send all of the relevant circulars from the Chief Nursing Officer's office to the Head of Nursing.

1189. Who decides what is appropriate for dispersement?

(Mr Tait.) Yes.

1190. There is now a far wider range, you mentioned AIDS and we may get on to barrier nursing. You will be able to take the initiatives but only to a level that you will be advising and providing information?

(Mr Tait.) Yes, if he wanted advice or we thought he needed advice that would be relevant to the Prison Nursing Service.

1191. From then on it is their decision at

[Sir David Price *Contd.*]

their headquarters as to what is distributed or not?

*(*Mr *Tait.)* Yes.

1192. That is another point. What about the training of nursing staff or hospital officers in prison, are you consulted at all? Do you have any advisory role in this?

*(*Mr *Tait.)* As a Member of the Education Committee of the Prison Nursing Service we already provide advice. There is basic training for the hospital officers in our Special Hospitals and in the NHS which provides for experience in acute hospitals, psychiatric hospitals and regional secure units.

Chairman

1193. Are you satisfied there are enough nursing officers in Holloway, for example, and other womens' prisons, particularly where there are baby units as well?

*(*Mr *Tait.)* I think it is difficult for us to answer because I am not aware of the details. I do know the Prison Nursing Service does have problems in recruitment of staff and is seeking to increase the numbers of trained staff. The problem is other hospitals are also looking for staff so we will all be drawing from the same pool, particularly in the mental illness field where there is a shortage of all trained staff.

Mr Patchett

1194. In Scotland, hospital officer training is given at NHS nurse training schools for two years up to SEN level. Would the NHS be willing or able to offer such training to the Prison Medical Service staff in England and Wales?

*(*Mr *Tait.)* I think that would be a policy decision for the Prison Nursing Service to take but if they wish to sponsor some hospital officers to undertake qualifying training I am sure the NHS would assist and help.

1195. In your memorandum you do state in paragraph 8 that the structure of accountable management in the NHS would not rest easily with the management and training of a service which required a high degree of national consistency, why is it not equally possible to argue the existence of well-defined management structures in the NHS at district level could make liaison between local prison establishments and local NHS services easier? Is there a contradiction here?

*(*Mr *McGinnis.)* I do not think there is. I think the point is the structure of the NHS as it is now is geared to deal with the responsibility for setting regional and district policy within the broad guidelines that come from the centre. The general managers at regional and district level are accountable for fulfilling the standards and meeting the objectives set for their particular patches although there obviously has to be some consistency within the NHS between one region and another and one district and another. The whole policy in recent years has been to set broad objectives and guidelines at the centre and each district according to the resources available has to implement those objectives within those broad guidelines. If what is wanted by the PMS is, in fact, consistency within all of the units within that service right across the country it is self-evidently not going to be easy to obtain that within Districts with delegated responsibilities for setting their own standards and doing their own thing. I do not want to suggest all of this is impossible because of the current organisation: if the Home Secretary wished it to be done and the Secretary of State for Social Services agreed with him the thing could be made to work whatever the current structure of the NHS. As the NHS is at the moment there are certainly difficulties that face that particular approach because of the way the structure is and the way it operates.

Mr Winterton

1196. Can we stay with your memorandum, and refer particularly to paragraph 11 where you talk about links with the National Health Service and you refer there to possible, and may I quote the phrase you used, unintended "side effects" of the absorption of the Prison Medical Service into the National Health Service. Could you perhaps explain to the Committee precisely what you and your colleagues meant by unintended "side effects"?

*(*Mr *McGinnis.)* It is really repeating in a rather more vague and general form the point made earlier in the paper. If the incorporation of the Prison Medical Service into the National Health Service were done without some means to ensure standards were nationally dictated and guaranteed, in other words if the organisation were in part as we have got it now with delegation to regions and districts to work out their own salvation you are going to get decisions based on appraisals by the health authorities of the sum total of the demands on them—among which would be the demand for a

[Mr Winterton *Contd.*]

service for a particular prison. Without a guarantee that that has come top of their list, it is inevitable that in some places, particularly those struggling with "Rawped" financing, (which means they are actually losing money as it is being transferred from inner cities, where arguably there has been too much medicine, to outer areas, where arguably there has been too little medicine), the Prison Medical Service will suffer in comparison with other things. This is saying in vague form what has been said earlier. You cannot guarantee absolute priorities and ring fencing for funding if you incorporate the national service as it is now into a locally devolved structure.

1197. Do the doctors, forensic or otherwise, agree with that?

*(*Dr *Warnants.)* I do not think I am competent to answer; I am not sufficiently familiar with this aspect of the problem.

*(*Dr *Oliver.)* I would add that I think the remarks made by Mr McGinnis would apply equally to the professional view of integration. There is competition for resources inevitably at health authority level and decisions have to be taken at that level. It is not inconceivable that there could be considerable argument as to the appropriate use of resources even amongst psychiatrists within a particular district, and the outcome could be inconsistencies in priorities within districts. Whether or not that would be acceptable to the Prison Medical Service I am not altogether sure.

1198. Could we stay with integration which we have started to talk about? You will perhaps have appreciated from copies of the evidence you have already received that when the National Association for the Care and Rehabilitation of Offenders gave evidence to us they suggested a rather novel and different form of integration from those which are discussed in your memorandum, namely, that there should be a contractual relationship between each prison and the National Health Service whereby the Home Office would buy a certain level of service from the local National Health Service which would then be responsible for providing it and all medical staff in prisons would, as a result, be NHS employees. What do you think of this interesting, constructive, positive and perhaps quite helpful proposition?

*(*Mr *McGinnis.)* I am aware of the suggestion. My reaction is that there is no conceivable way it could work, because it is based on a misunderstanding. The only way a combination of a contractual obligation t provide a particular service and the reim bursement of the cost of that service coul work is if the local health authority wa actually obliged to sell the goods that th customer wants to buy from it and to mee standards specified by the customer. I ar trying to think of a parallel within th existing structure. There is, as the Commit tee knows, a certain amount of scope fc what I might loosely call private medicine t be linked with the NHS, and it is a matte for the particular health authority how far sells part of its total resources to the privat sector, recovering its costs as opposed to th extent to which it directly uses its resource There is no greater guarantee in the syster put forward that the Prison Medical Servic will in each and every case get what it want through purchasing by contract than there i in the system we discuss in our paper wher there is an obligation on the health authorit to provide some sort of prison medica service alongside all the other services. I other words, you do not have a built-i guarantee, and in the nature of things yo cannot have it, unless you say to the healt authority, "You shall sell this amount c resources to achieve a defined result in th Prison Medical Service."

[In the absence of the Chairman, S David Price was called to the Chair]

1199. If there was an additional marke for the National Health Service and the were prepared to consider taking on th responsibility for providing a medical ser vice in prisons, which could then budge and plan for it, do you not think, as I sough to lead you to think, it might be an interes ing and constructive proposal to look at as way of bringing NHS standards into th Prison Medical Service, because whether c not the criticisms we are receiving are righ or wrong, there are some who feel that th standard of medical service in prisons is nc what it should be; it should be of the sam standard as in the NHS.

*(*Mr *McGinnis.)* I hesitate to suggest tha any suggestion seriously made in this wa can be dismissed in a few minutes' discu sion, because that would not be doing justice, but a lot depends on the nature c the market. When you are dealing wit health services, there is no guarantee of th ability of a particular sector or locality t buy those services, particularly if you a talking of a number of nurses or doctors i some specialties. You cannot create tha supply simply by having the finance to pa

[Mr Winterton *Contd.*]

for it. The other thing which goes with that is the point I was trying to make earlier, that if it is possible to expand a particular sector of Health Service provision it is still encumbent, as things stand, on a health authority to say how it ought to be deployed. For example, if one were able to increase the number of forensic psychiatrists a health authority might not necessarily say that because there is a market for those people through the Prison Medical Service, that is their priority, as opposed to saying, for example, that they are developing a community mental health service and they desperately need psychiatrists for that, so if they are to have more psychiatrists they would see that as their priority. There is no simple answer to this alternative proposition, which I do not want to dismiss out of hand because that would be a bit too glib.

Mr Kennedy

1200. To come on to the problems you have outlined in your paper with the idea of special health authorities and the problems you envisage could come about, which are essentially ones of management, why do you think central management, either by DHSS or by some form of special health authority, would only constitute cosmetic integration with the health authorities?

*(*Mr *McGinnis.)* I think we can illustrate that cautiously by one practical example. At the moment the special hospital service discharged through the four hospitals is centrally managed. That will continue to be the case even under the structure Ministers have now announced, whereby there are local boards for the special hospitals, to which powers will be devolved in certain local aspects, it has been common experience in that service over the years that integration with the NHS and the avoidance of stigma for patients in the service has been achieved, to the extent it has been, only by an awful lot of work, some of it very frustrating, over a long period, despite the fact we are talking of the Secretary of State being directly responsible for one area of the service alongside his other responsibilities for the NHS as a whole. That being the situation of the special hospitals under the same Secretary of State, it seems probable that if that Secretary of State were running the Prison Medical Service alongside his general NHS responsibilities, the difficulties of stigma and problems of local liaison would be no less than they are with the special hospitals. Arguably, they might be more, plus the added dimension, which is the constitutional one, that if the role of the Prison Medical Service is not only to provide direct care for patients who happen to be prisoners but also to be involved in some sense in the management of the prison service, at least influencing it or guiding it from the point of view of medical and nursing standards, it is not self-evident that our Secretary of State's responsibilities would run easily with those of the Home Secretary.

1201. Can I just come back here to two specific points? You said there will always be problems associated with whatever way it is organised and even if we went into this direction it would not overcome the problems; is that not just an argument for saying whatever happens there are always problems? Why arguably might those problems be more?

*(*Mr *McGinnis.)* I think the starting point must be the question what is the objective? If the objective is to raise standards within the Prison Medical Service because of the judgment, and it is clearly not a judgment we can make from the DHSS, that those standards in the Prison Medical Service are not high enough there are means, other than organisational ones, of raising those standards; and the Committee has touched on those in terms of training and shared experience outside the Prison Medical Service, in the NHS and Special Hospitals and so on. If the objective of any change is in particular to make the Prison Medical Service more attractive to work in or to reduce its separateness from the NHS or to remove the stigma of the Prison Medical Service as a body concerned with a rather unpopular category of patient, I do not think you achieve any of those things by major management changes. There is always a price to be paid for major management change and I think the question is simply whether whatever gains there might be are sufficient to outweigh the probability of making improvements in other directions without the management changes.

Sir David Price

1202. Is not your fear more likely to be realised if integration took place with the Prison Medical Service being run by regional health authorities? If you have set the health authority those rather different management regimes surely within them you could have central control of the budget and ensure sufficient psychiatrists which seems to be one of the complaints at the moment?

[Sir David Price *Contd.*]

*(*Mr *McGinnis.)* The central approach, the management from the Department or through a central special health authority solves your budgeting problem in the sense that there is a single allocated budget for no other service but the Prison Medical Service in this case. This solves that problem in a way the distribution to regional health authorities leaves unsolved. It still does not let you get what you want because we have, from time to time, had difficulties in recruiting psychiatrists and psychologists for Special Hospitals. Part of the explanation for that lies in the shortage of those specialists anyway and part of it lies in the nature of the work which does not appeal to all of those who are professionally qualified to do it. They might be attracted towards it by having a central budget for a DHSS-led Prison Medical Service. But as regards incentives and the abolition of the stigma to get people to respond by coming into that service, it does not automatically solve those problems because it is a DHSS led service as opposed to a Home Office led service.

1203. This aspect of the Prison Medical Service you think would apply equally if you had a special authority?

*(*Mr *McGinnis.)* I think a special authority in a sense is relabelling without any change in substance because it is still separate from the NHS. There are no reasons for keeping it separate in terms of budget considerations. You have not solved the stigma of separateness but you have achieved a DHSS label instead of a Home Office label.

1204. You do not think it brings them any more into the main stream of the NHS?

*(*Mr *McGinnis.)* No.

Mr Kennedy

1205. Not to labour this to a point of theology, finally on this aspect of the question do you mean you would have to accept the existing parameters of the Secretary of State for Health and Social Services and the Home Secretary if you were starting to set up a Prison Medical Service today? Would you end up with essentially what we have?

*(*Mr *McGinnis.)* It is very difficult to answer that in any sensible way from a DHSS standpoint. If you had to create a Prison Medical Service what would be required would be a proper level of medical and nursing care for prisoners in hospital, a medical and nursing input of management into the prison service and so on, I think yo would have to set up something whic would look very much like the existin Prison Medical Service. I am only specula ing but my feeing is it would not look ver different.

Mr Winterton

1206. On the same line of discussion d you think links with regional secure uni would replicate the problem of recruitmer in Special Hospitals because you have ju mentioned the problems of employing ce tain specialists in Special Hospitals?

*(*Mr *McGinnis.)* Were you thinking some sort of authority running the secu units and the Prison Service?

1207. What you think of the possibilitie that might be open?

*(*Mr *McGinnis.)* I think the difficulty wit that concept is two-fold: the first one is th the regional secure units are very much pa and parcel of the general psychiatric servic although a few years ago when the secu programme was first launched it seemed lik a discrete category of patient for a discre place. I think the only way secure units ca do their job is by fitting into the network forensic services that runs from ordina psychiatric units in district hospita through secure units into specialist hospita at various points of the spectrum. There is question-mark about the survival of secu units in isolation to the extent that the depend on the local hospital resource There is also a question-mark over th success of the services they provide if the are cut off from the place from which the patients tend to come and to which the patients tend to go back when their peric in the secure unit is finished. I think that th secure unit service cut off from the gener psychiatric service makes absolutely r sense.

1208. You were saying, as we all kno the Special Hospitals are centrally admini tered, therefore I am trying to put this jigsa together to give you an opportunity providing us with an answer as to how yo thought this ingredient might work bett than the situation currently?

*(*Mr *McGinnis.)* This question goes to th management linking of forensic work do in prisons and secure units and Speci Hospitals. In a sense they are all part ar parcel of the same thing but so are the jo done by psychiatrists and nurses in gener

[Mr Winterton *Contd.*]

psychiatric hospitals. To try and establish that group as a discrete entity I do not think stops the problems of movement between one part and another entirely, I do not think you can solve most of these problems in organisational terms. Unfortunately we have to live with difficulties inherent in difficult work and with separate responsibilities all looking in different directions and seek on the points at which they abut each other to ease the process of communication to reach common ground on training and shared experience so the patients do not get hung up on the network of services we have created for them.

Mr Kennedy

1209. Going on to regional secure units; the Committee has heard in the course of the inquiry that the chances of transferring a mentally ill prisoner to a psychiatric hospital depend in part on the area that he or she comes from. We have heard instances of prisoners being kept in strip cells for considerable periods of time in prison because their district health authority does not have a bed. What is the DHSS doing to try and improve the availability of secure beds in all areas?

*(*Mr *McGinnis.)* Trying to keep the answer as short as I can, it is a question of spending quite a lot of time on work on the part of the Department over quite a long period. I think the main elements in the answer are, first, the Department, and more particularly ministers, have been emphasising the responsibilities of each health authority for looking after those patients who are the least attractive and most difficult. There is a natural tendency for any hospital, indeed any health authority, to try to avoid dealing with those patients who present most problems; it is a natural human tendency. In particular, the Mental Health Act emphasises the role of the region in terms of finding a bed for a patient who needs a bed and is not easy to place. The review meetings that Ministers hold and the hard-to-place exercise initiated with the regions separately and collectively have hammered home that message. You cannot rely on the special hospitals which are there to look after a small category of special patients and you cannot rely on secure units which have a special job for a limited time. We are talking of 18 months to two years as being the likely treatment period, and also you must provide special facilities for those who cannot be left to wander round the hospital grounds, so the vague figure of 2,000 lockable beds in hospitals reflects the extent to which in recent years, as opposed to what happened in 1959 when the Mental Health Act was passed, those hospitals have recognised responsibility for providing accommodation for people who at that point need to be locked up—I use that term loosely—and it has been acknowledged that they do indeed have facilities which are suitable for those sorts of patients.

1210. On the question of recognising responsibility, how is it that some areas, like Oxford, are able to get away with not setting up a regional secure unit at all?

*(*Mr *McGinnis.)* There are two answers to that. First of all, the secure unit programme as regards revenue costs was quite deliberately based, not on having earmarked money which could not be spent on anything other than secure units, but on top-slicing money which would otherwise have gone into the Health Service, more particularly to psychiatric facilities, and saying that money ought to be spent on secure provision and if in any region it has not proved possible to do that it must be spent on psychiatric provision. The reason for doing that, which is not the obvious way of financing a new service, was to ensure that the money was not lost altogether to the Health Service at the end of the year, it having been taken out of the Health Service in the first place. Over the years there has been a certain amount of debate as to precisely what form secure provision ought to take. That is illustrated by the fact that whereas there has been a policy over the years to plan on the concept of a single relatively self-contained secure unit, the proposals we are receiving now, most notably from South West Thames, are for much more dispersed services more closely integrated with the rest of the Health Service. So Oxford has not been drawing DHSS money into inappropriate things; it has taken longer to sort out its secure accommodation needs, and there are historical reasons for it. It may owe something to the fact that until recently it has not had a forensic pyshciatrist to help it on its course. Oxford has plans for a secure unit for mentally handicapped people and proposals for two secure units for mentally ill people to make up the sum total of its provision.

Mr Winterton

1211. You have almost trespassed into my next question, which you have a habit of

[Mr Winterton *Contd.*]

doing—in anticipation. Regional secure units will never by themselves be a solution to the problem of mentally ill prisoners. You refer in paragraph 21 to 2,000 lockable places elsewhere in psychiatric hospitals. How many of these will survive the policy of closing big psychiatric hospitals? That is the first question. The second question is: Are you planning to maintain a large number of lockable places, and how long will the 2,000 places be available?

*(*Mr *McGinnis.)* First of all, on the effect of closures, the current regional strategic plans suggest that we are talking about the closure of something like one-third of the large specialist mental illness hospitals over the next 10 years. That does not mean that the patients in the beds currently in use in those hospitals are going to disappear because we are talking about alternative in-patient arrangements as well as alternative community care arrangements. I think the Department, whether or not through its own fault, tends to be misunderstood as regards its mental illness policy. It is not a policy of doing without in-patient provision. There are those who argue that you do not need hospitals for dealing with mentally ill people. That has never been our policy. We are talking of closing hospitals which in many cases are half-empty and finding alternative accommodation for people who need care. Among that one-third some patients will require secure in-patient care of some kind, and if it is not provided in the same hospital, which is often an expensive way of doing it, it has to be provided in some alternative in-patient facility which is just as secure. On the second point about how far the secure units will overtake the 2,000 lockable beds, that 2,000 is a rather vague figure. It is a world away from the regional secure unit bed numbers—we have a fairly firm grasp of that. These numbers will change from time to time according to local hospital counting systems, but we are talking mainly, not about interim secure units which we might expect to be overtaken to a fair extent by the permanent regional secure unit beds, but about beds for patients for whom the regional secure units are probably not the appropriate form of disposal and for whom secure provision is needed outside the secure unit system, so I cannot talk in terms of precise numbers in 10 years. The aim is to capture the bed needs of the mentally ill population at that point when some of the current hospitals are closed, not to try to squeeze them into bedsitters, flats or bungalows where, because of their mental condition, they simply woul not fit.

1212. In the evidence already given to u during the course of our inquiry we hav heard of many instances of people hither in psychiatric hospitals who have bee discharged into the community and who a now in prisons when they should not reall be there at all; they are there because th psychiatric hospital beds are no longer i existence. There is now a rather unhelpf attitude in the hospitals about taking the people in, perhaps in some cases the hosp tals from which these people have bee discharged into the community. There clearly a problem, is there not?

*(*Mr *McGinnis.)* Yes, and it is difficult t talk about it in a brief space of time. The are a number of factors involved. The first that the Mental Health Act defines tho who can be detained because of their ment disorder in a hospital, and quite deliberate —because the professionals spent a lo time in processing the Bill which led up the Mental Health Act—it left out som people who need some sort of help, sanct ary or asylum but who cannot be detaine Going back far beyond the Mental Heal Act, there have always been a number people who have no family ties, no jobs an no real place where they are at home, o facet of whose problems is some sort mental disorder, and for those the psychi tric service has never provided very much an answer, even in the days of large hosp tals with lots of occupied beds. The thi area is the area of those who fit in son sense and at some time into the Ment Health Act definition but who are di charged at the point where the medic tribunal, or responsible medical officer, managers, think they are ready to go o into the community: where, perhaps b cause of inadequate support or no family job to go to, they fall into crime.

1213. Do you agree that in the comm nity care situation very often there a totally inadequate facilities to give to the people, that they do not equate to the li they have lived in hospitals where all t facilities exist for sheltered workshops, r creation and all the other facilities which with the more traditional psychiatric hosp tal? Do you not think that the programme being implemented far too fast and there a inadequate facilities, like day care centr and all the rest of it?

*(*Mr *McGinnis.)* I do not think so as it

[Mr Winterton *Contd.*]

operating at the moment. If we are talking about people who have been some time in a hospital as opposed to those who have short spells in hospital and that is their pattern: short spells in hospital, short spells outside. Those who have been a long time in hospital are not discharged by a doctor until that doctor is satisfied that there is an alternative out there for them. This has not always happened. It did not happen at the time that the Mental Health Act 1959 bit for the first time. I do not honestly believe that unplanned discharge is happening now. The hospital attempts to see what is happening on the ground. They are not pushing people out without some degree of certainty that there is something for them to go to. Community care does of course involve problems. It is more difficult to maintain medication if it is to be maintained outside the hospital than in it. To capture those people on a regular basis and to make sure they keep taking whatever it is they have to take, that is less easy. If you are talking about somebody out in the community, perhaps unemployed without a family and perhaps without any friends there is less of a secure environment out there than there is in hospital. It is a matter of judgment and, indeed, opinion as to whether somebody who has been in the back ward of a longstay hospital with very little contact with medical staff, comparatively little contact with nurses and very little in the way of defined individual programmes and almost no progress over a long time is better off in that setting where things are guaranteed like three meals a day rather than out in the freedom where there is a price to be paid.

Mr Winterton: I would love to continue to debate this with you.

Mr Favell

1214. Could I have one brief supplementary? Have there been any studies into this unsupported evidence we have heard from members of the Prison Medical Service that it is like a weighing scale, the more that go out into the community the more that end up in prison? Are there any statistics or is it merely an impression.

*(*Mr *McGinnis.)* I think I would give two answers: one is a lot of it must be based on impression; the second one is we are talking about two trends which might seem to correspond but that does not actually prove that the two things are linked to each other. As we know from statistics two lines can go up but the one line going up does not necessarily draw the other line up with it, they may be independent. As I understand it the experience in Scotland, where the inpatient approach to psychiatric care is rather more marked than in this country, has been the same as we have had in the prison population. I believe internationally that is also true.

*(*Dr *Warnants.)* I am not aware of such works but that does not mean they do not exist. I shall be pleased to look it up if it is required.*

Mr Favell: I think that would be of interest.

Sir David Price: We will be coming on to the question of how well the whole of this field has been studied and researched, the certain absence of reliable figures.

Mr Winterton

1215. We have been talking about mentally disordered and the mentally ill, what about accommodation for the mentally handicapped? Are you referring to them in the answers you are giving to me? What plans are there in the health service for them? I say this perhaps with a lot of self-interest because in my own constituency they are proposing the closure of the Mary Dendy Hospital which worries me strongly, the policy of community care seems to have its way with those at the top in my constituency and region. I am strongly opposed to it.

*(*Mr *McGinnis.)* I think there is a world of difference between, if I can use the term, the ordinary mentally handicapped person who has got no psychiatric disorder—their problem is simply their mental handicap—and those with psychiatric disorders. For the first sort of person, provided you have within your community care network things like adult training centres, things like further education opportunities for those capable of benefitting from them and things like good relations with the local community so that the local community is accepting and not rejecting. Given all of those conditions the evidence is that those mentally handicapped people are not only happier (because they say so) and have integrated well in the community, their level of

*Note by witnesses: L S Penrose in 1939 suggested that development of mental health services reduced the incidence of crime. Steadman and others in 1978 concluded that community care was not of itself a cause of crime leading to prison sentences but that those ex-psychiatric patients who offend were frequently people who had offended before admission to hospital. The only safe generalisation may be that those who are detained in hospital cannot offend in the community.

[Mr Winterton *Contd.*]

social skills, their level of activity, sometimes dramatically increases. I am saying that occurs across a very wide level of handicap. For example, a mentally handicapped child of 15 who for all 15 years has been on a liquidised diet, has been in a community care unit for six months and is now taking solid food because there has been sufficient staffing to spend the time helping the youngster to eat more normally like the rest of us. He and other youngsters have been given a choice for the first time in what they wear, what they eat and drink. Elderly mentally handicapped people who have come out of longstay institutions after perhaps 40 years have discovered the ability to make tea and cook toast and all of the other things we take for granted. The difficulty lies with those where the Committee's current concern lies and that is mentally handicapped people who have got a psychiatric disorder or are autistic or have brain damage. Large mental handicap hospitals have always provided services for those people, they have been on locked "difficult wards" but at least they have had a place to be in. We cannot solve the problem through secure units because they take mildly mentally handicapped people not those who are severe—in other words those who will take four or five years as opposed to two years or six months to help. There is not much evidence that the behaviour disturbances found in the back wards of psychiatric hospitals are all successfully resolved when those concerned are put in domestic situations, though some of it is because they are bored stiff. What the Department is doing at the moment is two things: one we are using the Hester Adrian Research Centre to do research into the total extent of disordered mentally handicapped people, what their problems are, what the nature of those problems is. There is another research project which for the moment has gone out of my mind.* Then we are sending a team from the Department around the country to look at a whole range of proposals and actions for dealing with these people which range from specialist hospital care in the case of Morpeth to proposals for ordinary community care in the case of Sheffield. We want to take evidence on what is being done and what the results and costs are as a whole, from those active in this field and see if we can issue some guidance. I take entirely Mr Winterton's point. The one thing we must not do is close hospita providing a service and then think of a alternative. The alternative has to be ther first.

1216. Two quick questions but I thin you have perhaps answered the first par You obviously do not necessarily comm yourself to building the 2,000 mediu secure beds required by the Butler Commi tee, if not what about the 1,000 original agreed by the Secretary of State himself?

*(*Mr *McGinnis.)* We are on track towar 1,000. It has been a very slow process, a Members are well aware from having aske parliamentary questions about it. But we a on the way towards that sort of targe subject to the reservation I mentioned abo South West Thames, it is becoming obviou that we are probably not talking of 1,0C beds in identifiable, separately sited secu units. We are talking of something lik 1,000 beds in earmarked secure facilities provide relatively short-term intensive ca with high staffing ratios for people who nee that sort of regime.

1217. Finally, in 1981 the Home Affai Committee recommended that the NH should be required by statute—and I choo my words carefully—to provide NHS plac for any mentally disordered offenders mad subject to hospital orders. Mr McGinni you know and the Committee knows th nothing has been done to implement th recommendation. Is it still under consider tion within the Department?

*(*Mr *McGinnis.)* I think the answer to th question is "no", and it is "no" because the time of the passage of the Mental Heal (Amendment) Bill, leading up to the Ment Health Act 1983, Mr Clarke said two thing One was that under section 39, I believ what the courts could do was require th regional medical officer to provide a stat ment about not only the ability of h authority but the ability of other authoritie if necessary, to provide for particular p tients for whom the courts wanted to ha hospital places. It has not been necessary use it all that much, but it has been fallback provision where the normal cha nels have not worked as well as they shou have. The other part of the statement w the statement that he was launching h hard-to-place initiative. As I have spok about it twice already I ought not to s much more about it. But these are the tw parts of the answer at that stage, and it w seen by Ministers and in a sense accepted Parliament, in view of the nature of th

*Research into violence among mentally handicapped people.

Mr Winterton *Contd.*]

Mental Health Act, as a better alternative than trying to force a patient on doctors and authorities who felt there was nothing they could offer.

1218. Do you require health authorities to fund private hospital care for prisoners which authorities are not prepared to admit to NHS hospitals?

*(*Mr *McGinnis.)* There is a sense in which this happens. There is a limited amount of private nursing home or hospital provision which can provide the security we are talking about. To the extent some can, such as St Andrews. Health authorities are doing this, and the Department, particularly in responding to requests for special hospital beds in default of NHS beds being available, take the line that the responsibility rests with the regional health authority to provide for those patients who need security for which special hospitals are not designed to cater, and if there is no other way that an authority can meet its responsibilities it ought to be meeting them through the funding of private places.

Mr Kennedy

1219. Your anticipation continues. The Expenditure Committee recommended that where health authorities could not provide a place in hospital for a mentally ill person who needed to be transferred to hospital, the relevant health authority should be charged for the cost of treating that person in prison. Can we clarify the policy of the DHSS on that? Going back to what we said earlier, would that be, depending on which way you look at it, either a carrot or stick to encourage Oxford to move in the direction we both might desire?

*(*Mr *McGinnis.)* I would be very apprehensive about doing that. If we are talking about a patient for whom it is agreed the appropriate placement is a hospital, I do not think the DHSS ought to be encouraging or making the health authority pay for that patient to stay where he should not be—in prison. This is pure speculation, but if health authorities were able to discharge their responsibilities in that way and it was a more attractive proposition financially to pay for patients to stay in the wrong place than provide more of the right facilities in the Health Service, on the face of it it would not seem to be a very good public policy notion.

1220. I am thinking of the sort of Eindhoven notions which have been floating around in the Health Service in which various parties have expressed interest?

*(*Mr *McGinnis.)* I would argue that to ask a health authority to pay for a private place in a suitable facility is one thing but to require a health authority to pay for somebody to be in prison where he or she should not be makes no sense in terms of the Secretary of State's responsibilities.

1221. In paragraph 12(vi) you refer to training opportunities in the special hospitals and RSUs for prison medical officers and nursing staff. From some of the visits we have undertaken, it struck us that these can often amount to little more than short visits, say of about a week. Are you planning to improve training opportunities for hospital officers and PMOs in the NHS?

*(*Mr *Tait.)* Whether or not we are planning anything, I think it is for the Prison Medical Service to decide whether or not they want to have more training available in the NHS or special hospitals. As far as special hospitals are concerned, we would look at that very favourably indeed. We would be quite willing to provide additional training opportunities, not necessarily only for the basic training of hospital officers but also for professional development of qualified nurses in the Prison Medical Service, and some local health authorities would be prepared to look at it for the updating of qualified staff.

1222. Based on the fact that this is something you favour, because that is clearly implied, obviously there is a need for more of it, so does it not bring us back to the argument that if you had more say we might not have the apparent reluctance for this to happen in the Home Office that we have at the moment, or is that a leading question?

*(*Dr *Warnants.)* May I say something about doctors. Talking about the secondment of doctors from the Prison Medical Service to spend some time in special hospitals, we have such an arrangement which has existed for some years. I believe that at the present time there is one person there in one of the special hospitals, but for a period of several years we had no prison medical officer because we were told they were below complement and could not spare anyone. The arrangements for making a secondment to a special hospital are made between the Prison Medical Service and the hospital directly.

Sir David Price: That is a very general

[Mr Kennedy *Contd.*]

characteristic of any service that is short staffed; it becomes very difficult to do the desirable thing in relation to careers, training and so on; we get it right across the board. We are most grateful to you for drawing it to our attention. We have already had a good deal of evidence in this direction.

Mr Favell

1223. You refer in paragraph 18(d) to a DHSS working group looking at the provision of places for people who are mentally handicapped and also mentally ill or disordered. When was it set up, and what progress has it made? Who is it to report to and when? Is the PMS or the Home Office associated with the study?

*(*Mr *McGinnis.)* It consists of an interdisciplinary group from the DHSS; so it is a group comprising a nurse, a social worker, a doctor and an administrator who are concerned with mentally handicapped people. That group has been in existence for about a couple of months. Speaking off the cuff, their remit, apart from the research to which I referred, is to look at the extent and nature and effectiveness of the provision made for the more difficult mentally handicapped people basically in three settings: in mental handicap hospitals, in psychiatric hospitals and in what are loosely called community care centres. The end product is to be an internal report, but that in turn will lead to consultation with the Health Service and then with the Prison Medical Service—they have so far not been involved—to see if it is possible to produce guidelines. Therefore, to refer back to Mr Winterton's point, as part of the process of substituting alternatives for the mental handicap service as it is now, it will be possible to make provision as effectively as possible for those very difficult folk in the new style of service.

Sir David Price

1224. Can we move on now to Paragraph 20. You quoted a figure of about 100 mentally ill sentenced prisoners at any one time who ought not to be in prison but in hospital. We heard from practically every witness before us about this problem but what about the unreliability of this particular figure? How satisfactory do you think the arrangements are for calculating? How much weight do you put on the figure of 100?

*(*Mr *McGinnis.)* If I can start, Chairman, and then Dr Warnants can come in as he has worked in a prison as well as being forensic psychiatrist and can probably hel The figures have tended to vary over th years according to the point in time at whic they are drawn up. The firmest figure is th list of patients in respect of whom th Prison Medical Service has decided the ought to be in a National Health Servic hospital and has got professional backir for that view and has made a bid, succes fully or otherwise, to get that patient tran ferred. The particular figure spoken of in th past has been 700 or even more and tende to be a vague description of those patients i hospital, some detainable under the Ment Health Act, some transferred from hospit and some not, who present difficulties wit some mental problem and who are as har to handle in prison as they would b anywhere else. The figure of round abou 100 is one that I find fairly convincing and think I am right in saying that figure remarkably near that of Dr Kilgour who ha been very concerned to get a specific figu which reflects reality rather than a broa brush view.

1225. This is done by actually adding u specific cases about which there is no argu ment, and that being the hard core?

*(*Mr *McGinnis.)* Yes, there might be debate in those individual cases but at lea it is firmly related to named prisoner patients as opposed to the degree of ment disturbance among prisoners.

*(*Dr *Warnants.)* I left the Prison Medic Service in 1973 and the population of th prisons has increased since then. I hop there is no connection! We really can on go on the returns of prisons because that all we have to go by. You are likely to ha the figures in front of you for March 198 and September 1985, and in Septemb 1985 there were 10 mentally ill sentence which is probably close to the 100 me tioned. I am afraid that is all I know. I wou suspect there would be more figures whic are not fully recognised but I have no way gauging or guessing what it would be.

1226. This gets us on to a point v touched earlier and I said we would con back to and that is the evidence we ha been given about the lack of adequa research on health, particularly on the ps chiatric needs of prisoners including th numbers in need of hospital protection. W do not get the impression that anyone willing to fund such research. Can I ask yo and your medical colleagues do you fe

[Sir David Price *Contd.*]

there is a lack of secure information, do you feel there should be more research and if so—the second question—who ought to fund it?

(Mr McGinnis.) I think if we are talking about research into the prison population I have to be a little defensive and say it is the Home Office's responsibility and not that of the DHSS; but having said that if I can add a gloss: it seems to me we are talking about—I was going to say a captive population—a population of named and known individuals and particularly if it is those individuals who are not in and out very quickly but those who are in prison for a time research is a less obvious road into this than an assessment of individuals. Clearly the argument for research is that that is the best way of achieving a picture over a shorter or longer period which cannot be obtained by individual assessment because there are too many people to deal with. If we are talking in particular about longstay prisoners and disturbed prisoners my uninformed view (because it is from the outside) is that the right road to approach that problem is assessment of individual prisoners rather than researching a sample of them.

1227. So you can get it absolutely spot on at any moment in time?

(Mr McGinnis.) Yes, particularly if it is true that the number of prisoners who are actually within the range of the Mental Health Act as opposed to those who have got a lesser order of difficulty is fairly small then the individual approach does seem to have more possibilities than the research one.

1228. Do you feel this is being done adequately at the moment?

(Mr McGinnis.) I cannot really comment I am afraid. We look into the Prison Medical Service from the outside because of the point at which this touches on the National Health Service. I cannot pretend to judge looking from the inside.

1229. Would any of the doctors like to add anything?

(Dr Warnants.) I have to say I think one can look to research as the way to find a solution whereas I have seldom seen solutions arising out of research, with noticeable exceptions such as penicillin. I think to go and look at research and say "We need more research in this, we need more research in that" is probably not the best value for money. I think what one needs is for people with ideas to come forward asking for funds. Beyond that I can only associate myself with Mr McGinnis and say this is essentially a Home Office aspect of things.

1230. You are satisfied from a medical point of view that the information coming out of the Prison Medical Service you feel is adequate, you do not feel there are any great gaps in it?

(Mr McGinnis.) The picture we are getting of the number of prisoners who ought to be our patients is far better than it used to be and I think probably gives a reasonably good picture of what the actual situation is.

Mr Winterton

1231. Turning to Special Hospitals: now that each Special Hospital is to be run by a local management board how does the DHSS view the future arrangements for the admission or transfer of patients to Special Hospitals? To put one or two direct questions which I do not think should take too long to answer: what is the future of the Office Committee for the Special Hospitals within the DHSS? Will consultants working in the Special Hospitals have the freedom to accept or reject recommendations for a bed?

(Mr McGinnis.) We will still be talking about a Special Hospital Service which is run through four Special Hospitals. We will I think, subject to ministerial decisions, still be talking about a system in which the admissions to a Special Hospital are centrally controlled. The system at the moment is that where there is a proposal that a patient should be admitted it is normal for a Special Hospital consultant to look at that patient and report but the decision is a centralised one. That was based on our experience of the Special Hospital population expanding almost exponentially with rather vague criteria as to who should be in Special Hospitals and who should not. The control of admissions would continue and would not devolve to individual consultants in Special Hospitals. The standards are bound to vary between any group of professionals, however good they are. As regards transfers, the introduction of the boards may mean, if Rampton is anything to go by, relationships that the boards establish with health authorities and local authorities in terms of easing the process of transferring patients who ought not to be in a Special Hospital.

1232. Am I being oversensitive and sus-

[Mr Winterton *Contd.*]

picious when I feel in these arrangements I have just been talking about in the question I put to you that there may be implications in the proposal that the Prison Medical Service should come under a special health authority?

*(*Mr *McGinnis.)* I do not think so. The reason for the boards is simply the experience of Rampton Hospital that it is good for the hospital and its management team to have a local body of people between it and the Office Committee and the Secretary of State, people who are around the hospital more than we are and are informed directly from experience about its needs and are able to represent its interests locally. I do not think there is any automatic leap across to the future of the Prison Medical Service.

1233. You do not think it is logical we might be considering a special alternative for the Prison Medical Service in the relatively near future, perhaps as a result of our report or prompted by the report of the inquiry which we are currently carrying out?

*(*Mr *McGinnis.)* I think you might almost read the opposite into the fact that there will be a special health authority for Rampton Hospital and the two Liverpool hospitals and for Broadmoor rather than a central special hospitals health authority.

1234. Section 35 of the Mental Health Act allows a court to remand an accused person to hospital for a report on his mental condition; section 36 permits remand to hospital for treatment. Neither has been much used so far. Why do you think this is? Is it possible for a person to be remanded both for reports and for treatment, and do you think that should be possible?

*(*Mr *McGinnis.)* I am venturing on to territory which is not part of my day to day work, and I hope I do not get it wrong and mislead you. I think the reason for the distinction between the two sections is that you are dealing with different degrees of probability. Under section 35 you are dealing with a broader range of potential patients and a greater degree of uncertainty as to whether hospitals can do anything for them. When one comes to section 36, one is talking of a narrowly defined range of patients whose admission to hospital can provide some treatment which will be of benefit to them either in terms of making them better than they are or stopping them getting worse than they are. That is the sole reason for the distinction between the two.

1235. Do you think section 35(4) (r ports) and section 36 (treatment) can l used together?

*(*Mr *McGinnis.)* I think the reason fi using section 35 as opposed to section 36 a sense rules out using the two together. you have sufficient certainty as to the ne for that person to be in hospital you ought be using section 36; if you have son uncertainty as to the nature of the conditi and whether the person can benefit fro treatment, you use section 35 and get report to point the way ahead. In a situati where a person having been admitted hospital under section 35 for assessme proves to be in urgent need of treatment, t other provisions of the Mental Health A enable the hospital to grapple with th immediate need; the hospital does not ha to sit and wait for another few wee because the patient is there only under assessment and not under a treatment ord

*(*Dr *Warnants.)* One additional poi which points to a difference in substan and intent is that you require two doct for a section 36 committal.

1236. One understands that doctors oft find it difficult to treat patients unc section 35, and section 36 is limited mental illness and severe mental impa ment which is considered at crown cou level. Is that not correct, and, if so, is it n even more complicated than you imply?

*(*Mr *McGinnis.)* Yes, it is. The questio did not touch on was in a sense the questi whether Parliament had got it right, becau that section has not been much used yet a it does present some difficulties to so doctors seeking to use it. Given the re tively short time it has been in force, it i little early to judge that Parliament got wrong, even if it were for me as a simp civil servant to say such a thing. One bound to see interesting developments a result of using the Act, and as those who a professionally involved grapple with t code of practice and other guidance comes available there will be a need reconsider some provisions; indeed, would be surprising with this complicat piece of legislation if that did not happe

1237. But it is not as simple to mo from section 35 to section 36, becau section 36 refers to mental illness and seve mental impairment, and that section is us in the crown courts?

*(*Mr *McGinnis.)* The only point I w making—and I am afraid I cannot quote t

Mr Winterton *Contd.*]

section—was that if a patient proved to be in urgent need of treatment once he was in hospital for assessment you would not need to rely on section 36, because it is possible to give urgent treatment under other provisions.

(Dr Warnants.) I think there is a clearly intended distinction between mental illness and severe mental impairment to the extent that there is not as high a requirement as is the case in psychopathic disorders or mental impairment; there is a requirement for the purposes of detention that the patient will respond to treatment, whereas for mental illness and severe mental impairment it is only necessary to satisfy the court of the nature of the condition, and that treatment is required. In the case of psychopathic disorders and mental impairment there is an additional bit which says "to alleviate or prevent the deterioration of". In a nutshell, one can say that in the case of mental illness and severe subnormality it is important to act rather more quickly, whereas you have more time in psychopathic disorders and mental impairment to consider the issues.

Mr Favell

1238. This was something we touched on earlier. In view of the recent High Court decisions in *Regina v Hallstrom* and *Regina v Gardner*, are there any plans to introduce legislation to provide for community treatment orders, and what do you think about that idea?

(Mr McGinnis.) The Royal College of Psychiatrists has given some consideration to the issue and has tentatively tabled certain proposals. The Mental Health Act Commission goes into its spring conference tomorrow and will have before it a paper on this very issue of treatment out in the community. In the wake of the Royal College's work and the Mental Health Act Commission's work we in the Department will be concerned to seek the best way ahead. As a non-professional, the only thing I can say tentatively is that there must be a sense in which it can never be as easy to treat out in the community somebody who needs regular treatment, basically in the sense of taking drugs, as it is in hospital, not simply because of the statutory framework of the Mental Health Act but because in hospital, whether one is an ordinary patient or a psychiatric patient, one is subject to the ethos of the place which makes one more likely to do that which professional advisers want one to do. Outside, one is relying on voluntary help, a good system of registration and recall and the back-up of psychiatric nurses to get the patient to the right place for the right treatment. A community treatment order which simply says, wishfully, that a person will be compelled whilst living in his own home and amongst his own family to have treatment seems to me to achieve very little because the means of enforcing it are non-existent. The only means of achieving that result must lie in conditional discharge from hospital or some means by which a hospital reaches out into the community to keep within its grasp a patient who requires continuing medication.

1239. At all times the security of the public has to be paramount?

(Mr McGinnis.) Yes. Some of the patients who without continuing medication would break down do not present an immediate threat to the public; they will fall in on themselves first rather than on their next door neighbours. It is very important that they get the help they need quickly, but I do not think a lapse of treatment will necessarily involve the sort of violence we see in television shows; it is usually the patient who suffers dreadfully rather than the next door neighbour.

1240. The courts now have the power to make an interim hospital order under Section 38 of the Act. To date there have been very few such orders, why do you think this is? Are you trying to ensure that the courts are fully aware of this option and could it not be more useful in reducing the number of mentally ill people in prison?

(Mr McGinnis.) The courts, I think, are fairly well aware of this. One of the steps we have taken is to produce in conjunction with the Home Office a paper for judges. This was because the judges were anxious to get a clear picture, including the DHSS perspective, of what options were open to them. I think we have done what we can to make sure that the existence of the provision is known to those who can make use of it. As regards the reason for the currently low numbers, I am not sure that I have got a good answer. Part of the answer must be that the provisions as opposed to the rest of the Mental Health Act are still fairly recent. The figures we gave to the Committee relate to 1984; we have talked about the provisions but they had hardly come into existence at that time. We will be more

[Mr Favell *Contd.*]

worried if the figures for 1985–86 still show numbers at that level.

Sir David Price

1241. Can I just put a last question to you. Many witnesses before us have advocated some form of outside inspection of the Prison Medical Service, do you think that the roles of, for instance, the Health Advisory Service or the Mental Health Act Commission or Community Health Councils could be extended to cover the Prison Medical Service or would you prefer a new and separate body? Do you not think there is any need to do that?

*(*Mr *McGinnis.)* Again, Chairman, I think part of that answer must fall to the Home Office rather than the DHSS because it is its service we are talking about. The Health Advisory Service is a relatively small body composed of basically Health Service professionals which looks at psychiatric and geriatric hospitals. Without a considerable increase in its complement there is no way it could provide a regular input to the mon toring of the service in prisons. The same true as regards the National Developme Team for Mentally Handicapped People. regards the Community Health Counci they might have a valuable role in the ability to work with health authorities ar learn about health authority facilities. think any body going to monitor in valuable and informed way the function the Prison Medical Service would have to one that could inform itself about the pris service as a whole as well as the Pris Medical Service.

1242. Do you think another alternati might be to have a few medically qualifi people amongst prison visitors?

*(*Mr *McGinnis.)* I think if I were a Hon Office official as opposed to a DHSS on would be more inclined to look in th direction than in that of an existing heal service monitoring body.

Sir David Price: Thank you very much f giving evidence today.

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PRISON MEDICAL SERVICE

MINUTES OF EVIDENCE

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WEDNESDAY 26 MARCH 1986

Members present:

Mrs Renée Short, in the Chair

Mr Tony Favell
Mr Roy Galley
Mr Charles Kennedy
Sir David Price
Mr Nicholas Winterton
Mr Tim Yeo

Examination of Witnesses

THE LORD GLENARTHUR, a Member of the House of Lords, attending by leave of that House, Minister of State, Home Office, examined. DR JOHN KILGOUR, Director of Prison Medical Services, Home Office, called in and further examined.

Chairman

1243. Minister, thank you for agreeing to come and help the Committee with their current inquiry on the Prison Medical Service. Dr Kilgour, we have met before, I think on two occasions.

(Dr Kilgour.) This is the third.

1244. You are being very generous with your time.

(Dr Kilgour.) You are being very kind in inviting us.

1245. We are really trying to probe the Minister's views now because we always have a mopping up exercise with the Minister responsible towards the end of an inquiry. Can I ask you if you accept that, however undeserved you may think it is, there is a worrying lack of public confidence in the Prison Medical Service? Has this reached you? If so, what are you doing to allay the public's fears?

(Lord Glenarthur). I think if there is a lack of confidence it stems from ignorance of what prison life is all about in general. I think many of us who find ourselves suddenly involved in the prison world come into it full of preconceived ideas and when we actually dig into it a bit deeper we find there is a great deal of good going on and there is a great deal of hard work put into every aspect of prison life, including the Prison Medical Service. So I think it is important to educate people at large about precisely what is being done within the Prison Medical Service and certainly the sort of work that this Committee is doing will help, I think, to bring out into the open the sort of conditions which exist in the widest sense within the whole of the Prison Medical Service.

1246. What is your Department doing?

(Lord Glenarthur). We are doing a number of things to try and encourage a general interest. If people want to visit prisons, for example, then there is no reason why sensible approaches cannot be made for them to do so. Various publicity agencies —television and so on—have recently asked to go and look at certain aspects and I have been very keen for them to do so because there is nothing to hide there.

1247. Members of Parliament do get a lot of letters from constituents who are in prison, of course.

(Lord Glenarthur). Yes.

1248. One assumes that when people write to their Members of Parliament they are fairly well grounded letters, that they are not just rather hysterical outbursts, and this is a matter of very great concern. It has been suggested by a number of witnesses that we have met so far, both here in the House and when we have been visiting out in the country, that there ought to be some sort of independent check or inspection of the Prison Medical Service. What would the Home Office policy be towards that proposal?

(Lord Glenarthur). I think that one has to realise there already is an independent inspectorate. Her Majesty's Chief Inspector of Prisons has a doctor on his team and prisons are inspected regularly by the inspectorate. I think that there may well be a possibility of examining whether or not the

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medical side of the inspectorate should be strengthened in some way and that is something that we can give consideration to.

1249. But your inspectorate is not independent, is it, it is a Home Office inspectorate. What sort of independent inspectorate would you support?
*(*Lord *Glenarthur).* With respect, it is independent in so far as the Chief Inspector of Prisons is independent. He reports to the Secretary of State, but it is an independent inspectorate. I can assure you too from other aspects of it, although it is staffed to some extent by people who have direct experience of the prison world, they do not hesitate to make very clear recommendations on issues of all sorts to do with prisons.

1250. One suggestion put to us has been that there should be an independent medical inspector, or whatever you want to call him, on the medical side of prisons, not anyone involved with the Home Office inspection team or anything of that kind—perhaps a local general practitioner or a local consultant psychiatrist near the particular prison, but some independent medical person.
*(*Lord *Glenarthur).* I do think that it is important that links within the medical world, which includes the prison medical world, are strengthened to invite confidence in the system because I think there is much to be confident in. I do think too that it is important to bring in outside expertise such as that which is afforded by the Royal Colleges who have an interest as well, and this is an area that we are taking ahead. I do not believe that there is any lack of contact at all—in fact, I think the evidence shows quite the contrary—between the practitioners in the National Health Service and the practitioners who are within the Prison Service. Of course, some of them are part-time anyway and spend their time in both areas. So I do not think necessarily that a separate inspectorate along the lines you suggest is necessarily the right answer for more close collaboration, if you like, between the two types of service.

1251. What about the views of the doctor on your inspectorate who produces the report? Are his opinions available to the public?
*(*Lord *Glenarthur).* All the Prison Inspectorate reports are published, yes, and copies—

1252. Including the doctor's?
*(*Lord *Glenarthur).* So far as I know, ye They are included, yes.

1253. It is said that Prison Medical Off cers feel they are prevented by the terms the Official Secrets Act and Home Offi instructions from responding to allegatio of mistreatment, for example, in the loc press or from expressing themselves professional journals. What is your poli about that?
*(*Lord *Glenarthur).* All those who wo within prisons are civil servants and, ther fore, they are signatories to the Offic Secrets Act. I really do not think it is significant factor at all in any case a certainly not in the clinical management patients within the Prison Service. Again think it comes back to education of t public, which is a matter which we got to your first question. You asked about it. It a matter of informed discussion genera and I do not think that the Official Secr Act has any bearing on it at all.

1254. What you are saying is pris medical officers may write to the press, n necessarily the medical press, but the pre if they so wish?
*(*Lord *Glenarthur).* As it stands ma involved with prison medical work cont bute to learned journals and exchange th views; Dr Kilgour has himself and so ha others. An informed discussion about wh takes place in the clinical management prisons, of those who are ill, is an importa part of the general philosophy of educati on what takes place. What I do not belie has any bearing is the fact that tho concerned are signatories to the Offic Secrets Act, which applies whether you s it or not.

1255. If they wanted to write to a tional daily they would be able to do tha
*(*Lord *Glenarthur).* There is nothing stop them doing it. If they step outside terms of the Official Secrets Act that i matter for them, and no doubt for the cou at the end of the day. I do not think we talking about anything particularly sinist there is nothing to hide at all. If people ha a particular concern they can raise it.

1256. They are able to write freely to press without having their letters vetted?
*(*Lord *Glenarthur).* So far as I know, th are entitled to write to the press.
*(*Dr *Kilgour.)* What the Minister is say is absolutely right. There have been oc

[Chairman *Contd.*]

sions—I think it is reasonable for someone like myself, to my own staff, to say to them they are encouraged to make their contacts but, of course, if they are going to make a public announcement which would indicate they disagreed with official policy, I would regard it as a matter of courtesy that they would inform me first. There has been one occasion, to bring it down to hard tacks, and one occasion only, well publicised, where in the last two and a half years a letter did appear in the public press where I telephoned the writer within hours of reading the paper and suggested that if he had consulted me beforehand, one could have presented it in such a way that it still presented his views but in a way not to have caused any embarrassment to the Department. That is the only occasion where I have had to use any rein on that. I would encourage contacts very much. We have nothing to lose. It is ignorance which is our enemy.

1257. Have any prison medical officers been disciplined for speaking about any deficiencies that they found in the service?

*(*Lord *Glenarthur).* No.

*(*Dr *Kilgour.)* No, apart from that telephone call.

1258. Nothing happened to him afterwards?

*(*Dr *Kilgour.)* No.

Sir David Price

1259. Can I go back, Minister, to the point you talked about, encouraging responsible visitors to the prisons and bring this in with what the Chairman was putting to you, a question about independent inspection. It was suggested to us by representatives of the prison visitors that a way of satisfying both those aims would be to have, as a matter of habit, to always have, somebody medically trained on each panel of prison visitors?

*(*Lord *Glenarthur).* Are you asking about Boards of Visitors as opposed to prison visitors?

1260. Yes, Boards of Visitors.

*(*Lord *Glenarthur).* It is certainly an interesting suggestion. I make appointments for Boards of Visitors myself. If those who are medically trained come forward then it would be certainly very worthwhile to have them on the panel. I do not think it is necessary to make it an absolutely hard and fast rule that there should be a doctor or some medically trained person on the panel. In many cases there are nurses who have some medical training who are members of the Boards of Visitors. I do not think it would serve any useful purpose.

1261. We have particular evidence from one prison visitor who is a medical practitioner who is on a Board of Visitors and who found it has been of immense help with his professional training where he could talk to the prison medical officer without ruffling feathers.

*(*Lord *Glenarthur).* I am sure that is right and does happen. That example is a very good case in point. There are a number of doctors and nurses and a number of qualified medical staff on Boards of Visitors and they, no doubt, do manage to strike up a very good rapport with the Prison Medical Service because they speak the same language.

1262. Can we move on now to the presentation of statistics on the administration of drugs in prison. It has been widely criticised in evidence we have taken. Is not the best way to answer criticism of prescribing practice in the PMS to publish statistics in a rather more meaningful way than at present?

*(*Lord *Glenarthur).* I think this is something we have to look at, yes. There is always a difficulty in trying to publish statistics: what is the best way to set them out? What figures have to be taken into account? You know the story as well as I do. It is something we have to look at. What I think is true though, is that one should not read anything particularly sinister into the statistics. If one is talking about dosage and things like that, of great concern, I think the statistics on, for example, the amount of money spent per head per year in prisons comes out at less than for the population as a whole. I do believe that we can refine the ways the statistics are presented and I do not think there is anything sinister in what exists in the present statistics.

Mr Yeo

1263. A lot of the criticism of the PMS reflects on the alleged isolation of the service from the rest of the medical world. Would you like to say whether you accept that criticism?

*(*Lord *Glenarthur).* I do not think it is isolated in any other sense than the thrust of my answer to the Chairman's first question. There are a great many doctors in the prison service who are already working in the National Health Service a great deal of the

[Mr Yeo *Contd.*]

time. There is a great deal of cross-fertilisation of ideas between the two systems. Indeed, they are complementary to one another. One of them, the Prison Medical Service, has to cope with those who are in a different position from the rest of society.

1264. In the light of that, is it the policy of the Home Office to encourage as much movement between the National Health Service and the Prison Medical Service?

*(*Lord *Glenarthur).* What sort of movement.

1265. You refer to cross-fertilisation, are you keen people who maybe work primarily in the Prison Medical Service should gain as much exposure to the National Health Service as possible?

*(*Lord *Glenarthur).* They do have exposure in the case of the professional contacts they have, and those who work part-time naturally spend the rest of their time within the National Health Service world. I am very keen to encourage this part of the policy, but nevertheless the two elements are separate. What I said earlier about bringing the Royal Colleges more into play is another step in the direction of closer collaboration between the two services.

1266. How about the question of the prison medical officer pay scales; have you considered trying to bring those into line with the NHS in order to pursue the policy you have referred to?

*(*Lord *Glenarthur).* I would like to ask Dr Kilgour to answer the particular question. There are differences and he is better qualified to answer.

*(*Dr *Kilgour.)* There are differences. At the lower end of the medical officers' pay scale there is no doubt at all that the NHS general practitioner or the NHS post-graduate, or the junior consultant or the senior registrar is better paid than the Civil Servant. This is a problem, and the Cabinet Office Medical Officer Committee, chaired by Dr Acheson, meets twice a year and this is on its agenda at the moment. There is a project which seeks to make the senior medical officer grade the main working grade within the main medical civil service. It is, if I may say so, a very important question to us because the Prison Medical Service forms about a third of the total medical officer grade in the Civil Service, but is the only one in that grade which has clinical responsibilities for looking after individuals, a doctor-patient relationship. So it does make them very much more directly comparable to the part-timers who come in. Working side by side they do sometimes have a feeling of wantin a better deal on these grounds, but that i not to say that nothing is going on about i

1267. Do I get the impression that yo would favour bringing these into line?

*(*Dr *Kilgour.)* Oh, yes.

*(*Lord *Glenarthur).* I think it is ver important that the prison population a large do not imagine the Prison Medica Service is a poor relation to the Nationa Health Service, because it is not, it fulfilling a distinct role. In a way that w have described, the increasing attempt to tr and improve the functional integration an collaboration between the two services is a important part of how we go. I do think to it is important where you can match pa scales and things like that to bring conf dence to those who may or may not work i that particular field and this will go a lon way towards helping it.

Chairman

1268. There is a less attractive pay scal is there not, for Prison Medical Officers? D you not think that that does discourag them from working in the Prison Medic Service, or makes it difficult?

*(*Lord *Glenarthur).* I imagine yes. It ca not certainly make it any easier for ther There are differences in the two systems ar I have said the last thing I want to see is th Prison Medical Service become any more a poor relation than it may feel at th moment. You have heard what Dr Kilgo just said about hoping in due course of tim that it will be possible to match these thin more nearly.

1269. What is "due course of time How long is that?

*(*Lord *Glenarthur).* I do not know.

*(*Dr *Kilgour.)* It is on the table of th Cabinet Office Committee and has been f about a year.

1270. So you are keeping your finge crossed?

*(*Lord *Glenarthur).* Yes.

1271. Of course, if you did have pari between the two sections, the Nation Health Service and the Prison Medic Service, it might be easier to get more cro pollination within, Prison Medical Office perhaps taking National Health Service p tients' clinics or working in the NHS hosp tals, might it not, because then they wou not feel that they were rather different fr

[Chairman *Contd.*]

the NHS consultants, for example, who are paid at better rates? It might be a good thing, might it not, to mesh the two things in rather more?

*(*Lord *Glenarthur).* I think there are various ways in which the two can be meshed but I do not think it is possible to get away from the distinct atmosphere of the Prison Medical Service. If we need to use consultants, then we do use consultants from within the National Health Service in the normal way.

1272. I was talking about going the other way, from prison into the National Health Service or into the teaching hospitals, if you like. It would open the eyes of the medical students, would it not?

*(*Lord *Glenarthur).* I think it cetainly would, yes. No doubt that is a choice that can be made by individuals within the Prison Medical Service if they want to. There is nothing to stop a doctor going from the Prison Medical Service to the Health Service as it stands.

*(*Dr *Kilgour.)* We are, in fact, positively encouraging that as a policy. The difficulty, as I think I mentioned before, is really the question of numbers available at the moment; it is a question of when we can spare them for such tasks.

Mr Yeo

1273. Moving on to a slightly different topic, why does not the Home Office adopt the Scottish model whereby hospital officers or nursing officers can be trained in stated roles?

*(*Lord *Glenarthur).* The fact is that we are moving towards an improved system of training of nurses within the Prison Medical Service. The first thing to say is all women hospital officers are qualified as State Registered Nurses or State Enrolled Nurses, and we are now moving towards, as things stand, 140 out of about 900 hospital officers on the male side being qualified. We are introducing in-service training for others on specific skills. I do not myself believe it to be necessary for all hospital officers to be fully trained nurses any more than I believe it to be necessary, for example, for medical assistants in the Army to be fully qualified nurses. I think there is a parallel to be drawn between the two sets of circumstances if you like. I think it is a wonderful ideal that everybody should be fully trained in that way, but I do not think it is a practical suggestion.

1274. Do you have a target—you mentioned 140 out of 900—to which you are working?

*(*Lord *Glenarthur).* What we have done has been to increase the amount of training in any case from 12 to 24 weeks, which I know sounds small in comparison with the training of the State Registered Nurse, but nevertheless it is not a very great difference from the sort of training somebody such as a medical assistant in one of the Armed Services might do. I think what we can try and do there is to go towards qualification along the lines of that sort of training but I am not laying it down categorically. It would be something along those lines, perhaps categorised in three grades in which the top grade would be a really very highly trained hospital officer. Nevertheless, I do think it is important to have a number of fully trained nurses within the system.

1275. Where you have got hospital officers who want to acquire professional qualifications would you allow them to be seconded to the National Health Service or a nurse training establishment on their normal rates of pay?

*(*Lord *Glenarthur).* On their normal national rates of pay I will have to think for a second. There is another practical difficulty. That is actually sparing the staff to go and do long courses which last—I do not know how long a nurse's training is—I should think about five years. There needs to be consistency within that.

1276. Three years, I think.

*(*Lord *Glenarthur).* That is something which would have to be managed within the staff constraints, the staff total, within the Prison Medical Service. As for pay scales, I am afraid I cannot comment.

*(*Dr *Kilgour.)* You asked about interim targets. The interim target we are working on at the moment is in the male system that we should have 360 trained nurses in a period of about three years, and we hope very much we can. We have already done quite a bit of negotiation with the Prison Officers' Association and part of the agreement we have is taking very much into account the need to maintain the opportunities for those already in the Service. This would be constrained by a mixture of how many we could afford to let go at any one time, how many would want to volunteer for this—because by no means all of them would want to do it—and then a further constraint is those who are educationally capable of undergoing the course. So we

[Mr Yeo *Contd.*]

think that we can make a very significant offer which will satisfy the demand for that. It will certainly have to be done to some extent.

1277. Of course, not everyone would volunteer. That would make it easier for you to offer facilities to those who do volunteer. As I understand it, the Scottish Office does manage to do this. The question arises as to where and why the Home Office cannot match this.

*(*Lord *Glenarthur).* Really for the reasons I have given. I am not an expert on the Scottish model. I personally do not believe it to be necessary in England and Wales to go to fully qualified State Registered Nurses for all those who are hospital officers. I think to move to 360 out of 900—the figure you have just been given—with the development of something in between along the lines I suggested is the right way to proceed. I think to do any more would be unnecessary. One thing I think I ought to say is this: in the year I have had resonsibility for prisons—and I have been round a great many now—I have never found any evidence of anything other than very great professionalism exhibited by those hospital officers whom I have met, and I have met and spoken to quite a lot of them.

Chairman

1278. The better trained they are, the better one assumes would be the standard of medical or nursing care?

*(*Lord *Glenarthur).* Yes. I think that is right but what I am suggesting is that it is not necessary to go as far as fully training everybody to SRN status; I think to go to a third or rather more than a third, which is the figure Dr Kilgour has just given you, will go a very long way towards meeting the concerns that people feel about the qualification of hospital officers, and that will be further enhanced by in-house training to the level of standards of whatever it might be for the parallel with, for example, medical assistants in the Armed Services. I think that is certainly important in the existing system. I would have thought it would go a long way to provide an even better, greatly enhanced nursing service.

1279. I think that we would want to see better training for nurses working in the prison service. It does seem rather invidious that we are prepared to pay less well trained people who are acceptable in the prison service where they would not be acceptable in the National Health Service, bearing in mind the problems of the people they hav to deal with are very special problems tha prisoners have?

*(*Lord *Glenarthur).* Yes, and a lot c problems are different from the problem they have in the health service. It cut both ways. I think that the suggestion tha there is an inadequacy in the training c hospital officers, just because they do nc have SRN qualifications, is going too fa because the direction of treatment, the wa a patient in a prison hospital is looked afte is still the responsibility of the doctc concerned, and they would never authoris any treatment or anything to take place tha was not fully in accordance with the instruc tions the doctor had issued. I think the othe thing is, at the end of the day if a patient in prison cannot be treated any more in th prison he goes to the NHS hospital and wi be cared for by fully qualified nursing staf They do come into play at the end of the da anyway if somebody is very ill.

Mr Galley

1280. We have received a number c memoranda which suggest that som prison hospital officers, who are not traine nurses, are able to carry out a number c medical procedures such as suturin wounds, normally carried out by fairly we qualified nurses in the NHS. What is you policy?

*(*Lord *Glenarthur).* That comes very muc into line with the answer I gave just now c how we propose to develop the system i due course. There are those who are pe fectly adequately trained to carry out sutu ing, such as medical assistants in the mil tary, who are not fully qualified nurse There is a great deal of skill in these issu which do not necessarily need a full, thre year, qualified SRN. It does not represe any lack of care. In fact, I think one can g so far as to say that those who do th regularly are almost more expert than tho who do it once in a while but who are ve highly qualified.

Chairman

1281. What about injections?

*(*Lord *Glenarthur).* That would have be done by those who were, again, mo highly qualified in the field I have su gested we may go down. I can see no reas why a fully trained person of medic assistant status could not give an injectio Indeed they do. I have had injections fro them myself and never suffered any effects.

Mr Galley

1282. Does that apply to purely sedative drugs?

*(*Lord *Glenarthur).* The actual administering of a sedative drug is one that requires the most careful assessment by the doctor. These things are never given lightly. I do not think one can generalise and say any specific injections should or should not be given before a policy to do it has been fully worked out. I have given you ideas along the lines of which we might develop the system, and this is being developed at the moment. Precisely who would give an injection like that I do not think I can answer yet. There are real difficulties with that sort of thing and you have to be careful it is done under the supervision of the doctor, the administration of the doctor. It does not matter what particular substance it is, it has to be administered safely.

Mr Winterton

1283. Young children can inject themselves if they are suffering from diabetes, and a medical assistant can give an injection for many other things.

*(*Lord *Glenarthur).* That may well be the case. At the end of the day, one is talking about the safe administration of an injection. I do not think it is necessary for somebody to be a fully trained SRN before they give an injection. I was asked about sedative drugs. This is something one has to look at. Every single case is taken on its merits. Dr Kilgour can correct me if I am wrong, but if an injection has to be administered by a doctor, then it is.

*(*Dr *Kilgour.)* I only want to add to that to underline, first of all, the point that there are several skills which you can touch on, medical aid as opposed to fully trained nurses, in these ways one can do certain things like suturing or injections. The important safeguard is, the person who is responsible for giving the order or the instruction is the doctor in charge and there is no way of avoiding that. I try to make it very clear to staff, if they entrust certain duties to members of their staff it is still their responsibility and they should not entrust those tasks until they have assured themselves that the person asked to do it is safe and capable to do that.

1284. In battles in war ordinary soldiers are able to administer morphine injections?

*(*Dr *Kilgour.)* Yes.

Chairman

1285. That is not a proper parallel.

*(*Lord *Glenarthur).* No, it is not the same, particularly as we move into the realms of auto-injection. As one who has not plucked up the courage to stab myself with training aids for morphine——!

Chairman: I can do it!

Mr Favell

1286. In your experience have you come across any mishap as a result of a hospital officer administering wrongly a suture or injection?

*(*Lord *Glenarthur).* I have not.

*(*Dr *Kilgour.)* My experience of the prison service is two and a half years and no such incident has been brought to my notice. In my much longer medical experience, of about 40 years now, I have known of cases where it has gone wrong, in the case of doctors and nurses and in the hands of RAMC orderlies. These things do happen. I believe I am in danger of perhaps giving the impression of being on the defensive about this. I agree entirely with what underlines the question, which is, the more training and skills you have, the more appropriate qualifications in the group of the Prison Medical Service, whether doctors, nurses or hospital officers, the better the quality of the service.

Chairman

1287. The fewer crises you may have in a prison?

*(*Dr *Kilgour.)* Yes.

1288. We have to bear in mind if the NHS patient has an unfortunate occurrence after an injection, if he so wished he could sue the doctor; a prisoner cannot sue the prison.

*(*Dr *Kilgour.)* Yes, indeed they can. They have every opportunity in civil law to pursue this. Many, many of our medical officers have; most have been very successfully defended.

1289. Who would be sued, the officer who gave the injection?

*(*Dr *Kilgour.)* The doctor. I believe in law the person held responsible would be the person in charge.

1290. How many times has it happened?

*(*Dr *Kilgour.)* Not in the last two and a half years.

Mr Galley

1291. From the comments you have

[Mr Galley *Contd.*]

made you do not see the need for any national guidelines about who may do what at what level of qualification, or what hospital officer or nurse may carry out a particular medical procedure?

*(*Lord *Glenarthur).* No, I do not think national guidelines—because we already have examples within the military where a very, very high standard is achieved, which is different in some respects from the other side, for example, the military medical world where there are still fully trained nurses—I do not think national guidelines are necessary; but the answer is to develop a suitable and adequate level of skill. I really believe that different aspects can be developed better.

1292. You would not seek to liaise with the Central Council for Nursing?

*(*Lord *Glenarthur).* These bodies would be brought in. I do not think there is any intention to set about the development of all these things without bringing in the appropriate bodies and consulting them.

*(*Dr *Kilgour.)* Could I just add that we are, as the Minister indicated, in an advanced state of the negotiations to produce a group of the interested Royal Colleges to opine upon the standards of achievement that would make for a good Prison Medical Officer. What will immediately follow, I think, will be a parallel with the nursing and hospital side of the Prison Medical Service and I think all these things are probably about to occur—probably during this calendar year—helped, I believe, by the report of this Committee.

1293. Could we turn to the subject of suicide? We have been given some figures, I think, which suggested the suicide rate in prison is considerably greater than in the community at large. In 1984 the Chief Inspector recommended that the responsibility as far as possible for identifying potential cases of suicide should rest with the Prison Medical Officers. He also recommended greater training for medical officers and hospital officers in detecting and assessing suicide potential. What has been your response to those particular recommendations?

*(*Lord *Glenarthur).* The matter of suicides in prisons is a very disturbing one. I think one of the most striking things that I discovered when I started this job was finding reports of suicides landing on my desk. Having said that, I do think it is a very, very difficult world in which to predict. That is why we have been looking at the whole question of training, of identification of those at risk and every other factor that goes towards this sad and distressing business. What I can also say is that not only do I think it is, if a suicide occurs, something that is very disturbing for the prison as a whole, it is something which everybody in the Prison Service will do their level best to try and prevent under any circumstances. We have said recently in answer to a Parliamentary Question that the later report which takes into account the earlier report on this and tries to find a practical way ahead is now with Ministers and the conclusions will be published in due course. I repeat, it is a very distressing area and one that is likely to capture public imagination in a way which is understandable, but I do also want to stress particularly that it is a matter of the gravest concern to all those in the prison world.

Mr Winterton

1294. Are you not being very defensive about this, Minister, bearing in mind that people in prison are likely to be the people who will commit suicide, i.e. you are going to have a higher concentration of people potentially going to commit suicide than in the community at large? Is it not unfair to say that there is in prison a slightly higher incidence of suicide than in the community in general, in fact, bearing in mind the concentration of people who would potentially commit suicide inevitably bearing in mind their mental disorders, personality disorders etc.?

*(*Lord *Glenarthur).* I think that is absolutely right. I do not think it is possible to draw a strict parallel in the way that was suggested. What I was trying to develop and express was the concern we felt for them even though they were in that peculiar category that you describe. I think you are absolutely right, I think we have some very unfortunate people in all parts of the Prison Service as prison inmates and that can lead to a higher than normal rate. You would expect it to, as you say.

Mr Kennedy

1295. Is that the official medical opinion within the Home Office, that people in prison are more likely to commit suicide?

*(*Lord *Glenarthur).* I think it is. There is no official line on whether or not people are more inclined to; I think it is just common sense. It goes to show—and I think Dr Kilgour will bear me out on this—that those who have had fewer opportunities and for

[Mr Kennedy *Contd.*]

one reason or another do end up within prison are those who are concentrated, if you like, within the overall prison population and some of them are particularly distressed for one reason or another. Perhaps you would like to clarify——

Mr Winterton

1296. Before Dr Kilgour does could I ask a direct question, being provocative and the devil's advocate: would you not say perhaps because people are receiving pretty good care in prison medically they are less likely to commit suicide in prison because of the care and the day by day attention they are getting than if they were actually in the community?

*(*Lord *Glenarthur).* I suppose you could suggest that. I do not know how much validity there is in it honestly. Dr Kilgour might like to comment.

*(*Dr *Kilgour.)* There are two answers to this, I think. The first, if I could take it up just generally on a broad scale, is, as the Minister says quite rightly, the prison population is drawn from a very narrow part of the community and that part of the community is a very morbid community both physically and mentally and, therefore, it contains unstable people, as we see from their behaviour, what they do and what brings them into prison. So the next thing, as the Minister said quite rightly, is that when they come into prison they are being subjected to what they must regard as a menacing, threatening anxiety-producing environment; so if anybody has a tendency to be unstable quite certainly, however well the prisons are run, the fact of a prison environment is bound to accentuate it and aggravate it. We know, for instance, that the mode—I am using the word in an epidemiological sense, statistically—time of suicide is in a relatively young male who is probably early in his remand state and there is a small spike later on among those who are long-term prisoners who for various reasons have something like a "Dear John" letter late in their prison career. If I could make one other point—and this is widely used by most critics of the prison system and their attitude to suicide—I entirely support what the Minister was saying about the fact that one suicide in prison is too many because theoretically nothing happens in the prison environment without permission. Obviously, therefore, one suicide is too much. I am not trying to be lighthearted about that. It really is and it hits the prison staff very much. They all take it to heart, the morale of the establishment goes down quite remarkably when a suicide occurs. So I like to say most of the people who compare the statistics inside prison with those outside take the number of suicides successfully attempted in the course of a year and match against the population average the population of the prison. Now, that is a perfectly valid thing to do, but it should be explained—and it really is to me—a much more valid statistic would be the number of suicides in the course of the year related to the number of prison receptions in the year. Now, the prison population in the year averages about 46,000 to 47,000 but the number of people coming into prison, and therefore having that particular period when they first come in and are subject to all these strains, is nearer 170,000. So the sort of statistics you get per 100,000 are really probably three and a half times too high. Having said all that, I deplore even one.

Mr Galley

1297. Could you just clarify why you say it is three and a half times too high? I think the figures we have been given show the suicide rate at about four or five times higher in prison than in the community, which has to be a matter of very great concern.

*(*Dr *Kilgour.)* What I am saying is that in real terms it is probably about 50 per cent higher in the community or something like that; it is not by a factor of five, if you take my method of comparison as being a fairer way of doing it.

1298. Even so, should you not be a little more dynamic in your approach to the problem?

*(*Lord *Glenarthur).* We are rather more dynamic in our approach to the problem and that is why we have done a report. It concerned me from day one and work on the report was already in train. When it is finally approved and we have decided how to take it forward, I am sure that it will be widely regarded as a step in the right direction.

1299. Have you taken any interim steps to improve training and identification procedures?

*(*Lord *Glenarthur).* Yes, we have, under the existing system. Dr Kilgour might be able to describe them. Because it is a matter which always comes to me if there is any case of suicide and it is followed by a comprehensive follow-up report going into a great deal of detail on the history of the person concerned and the background to it all, I have been very, very keen to make sure

[Mr Galley *Contd.*]

that procedures have been followed up, and indeed they always have been followed up. There is no doubt at all that the prison service is very well aware of, for example, the not particularly satisfactory method of F marking—which you probably know all about—and for someone who is not F marked it does not mean to say, because he is not F marked, he may not present symptoms of suicide tendencies.

*(*Dr *Kilgour.)* There has been, first of all, a group who have been studying the Chief Inspector's report, whose views are just about to receive ministerial attention. I believe what comes out of that will undoubtedly be seen to be very much a practical step forward, full of practical advice; and some of the things I am quite certain will be included, and are already being taken on board by the Medical Service, are better training at all levels for the perception of the suicide risk, and that means not just doctors but hospital officers on reception and other members of the reception team, not necessarily the PMS. It is the reception area which is crucial. We have already had sessions for the routine hospital officer training programme on suicide prevention and I personally introduced that particular subject for the Principal Medical Officer and the Senior Medical Officer meetings.

Mr Winterton: I had some very good friends who were murdered at the Boarded Barn in Cheshire and one of the people found guilty, Anderson, committed suicide in prison by setting fire to his mattress. Can you tell me, Dr Kilgour, whether anything that you could have done could have, in fact, prevented that man who quite intentionally, because he had been found out for a vicious killing and was going to serve a long sentence, decided to end his own life, could you as senior person in the medical service in Her Majesty's Prisons have done anything about that?

Chairman: This is not *sub judice*, is it?

Mr Winterton

1300. No.

*(*Lord *Glenarthur).* Can I make a general comment before Dr Kilgour replies. Perhaps it is easier for me to do so because I am not a professional in this world as Dr Kilgour is. Could I say that in my experience in life people who really set about with the determined effort to kill themselves actually do; it depends how subtle and clever they are. It is frightfully difficult to get into their brains and decide why they might do it. Most people will realise that those who want to do so tragically succeed. You are suggesting whether or not Dr Kilgour might be in a position to say whether or not there was anything he could have done—this is not a very fair question, he has not got the facts in front of him.

1301. This death occurred actually under his period in office.

*(*Lord *Glenarthur).* If this person killed himself by setting fire to his mattress, the replacement mattress would be a fire-retardant, flame-resistant mattress, introduced some time ago. Mattresses are flame-proof.

*(*Dr *Kilgour.)* The process is going on. I would not like to pick specific cases; I think that one must not just say something out of one's depth. Taking as an example, I agree entirely on professional grounds there are three or four main groups of people who commit suicide; only in one area are we going to have any effect on prevention. The person who does it in self-disgust and does it out of the blue, such a person will always find the opportunity. It is the depressed people we can do something about, and offer the non-professional and some of the professionals, whose antennae are not twitchtering enough in this field—they have not been trained to be aware of it, to spot the fellow shuffling along at the back, the last person to respond to orders, and standing in the corner at the back, the chap who is not a very attractive fellow for the reception staff to deal with, and officials having to push them along—these are the people they have to become much more aware of. The others are people who are showing bizarre behaviour to attract attention anyway and the more psychopathic group who want to make a suicide gesture and do not realise how quickly, by accident, a gesture can become the real thing and how quickly you can die with a ligature round your neck.

Mr Kennedy

1302. The Committee has several questions on mentally disordered prisoners we would like to raise. We have heard during the course of the inquiry a lot about the lack of research into the numbers and needs of the mentally disordered inmates in prison. Do you accept that criticism?

*(*Lord *Glenarthur).* What I had understood from having had experience as minister on both sides of the fence, in the DHSS where I had a particular responsibility for mental health and the mentally handicapped and now for prisons, is that there are inevitably a number of people who are in prisons who either fulfil the terms of the Mental Health Act and ought not to be there

[Mr Kennedy *Contd.*]

and are being transferred out under sections of that Act, and that there are also those who do not fall neatly into the DHSS world or the prison world, and we must do what we can to identify those. We have, in fact, already set in hand a method of trying to identify those that do not fall within the Mental Health Act. We took a snapshot census on the 4th December last year to come up with some numbers to see how big the problem was. We are validating that information to try and take it forward. It is very much a concern of mine. I have seen both sides and it is certainly a valid criticism that there are those within prisons who ought not to be there because they are mentally disturbed in one way or another.

1303. When you talk about the need to validate the snapshot of the 4th December, what sort of timescale have you got in mind? What do you hope to be able to do with the information, depending on what it tells?

*(*Lord *Glenarthur).* What I want to do with it is to try and come to an arrangement through discussions, which has to go wider than just the Home Office, to bring in other departments as well and also the Social Services, to try and find a way of having fewer of these people in prison. I cannot put a timescale on it. It is under extremely active consideration at the moment. I have taken a number of initiatives forward in the course of the last few months to develop it. It is under active development. It takes quite a long time when you move into a new department and take over responsibilities for something as big as the prison service to identify the apparent areas that one can act upon. This is one I have a particular interest in, and one I am very keen to take forward. Nothing happens overnight. It is being pursued positively.

1304. You do mention provisions of the Mental Health Act. Going on from that, what is the Home Office itself doing as a body to try and encourage or ensure that the courts are making the most of the provisions?

*(*Lord *Glenarthur).* We do not hesitate to draw to the attention of the court the opportunities they have to deal with people of a particular type, and Sentence of the Court, which is the handbook for courts, has just been republished yesterday and that contains a chapter on mentally disordered offenders which goes into a great deal of detail as to what is available.

Mr Winterton

1305. Not just the mentally disordered but the mentally ill; you have appeared in at least one television programme about the mentally ill person and the psychiatric hospital. What are you doing very positively? Many of us in this House are deeply concerned about the numbers of people in prison who should not be in prison at all but a psychiatric hospital or undergoing some care under, as it were, the responsibility of a psychiatrist; many, we have found from our visits, who are people discharged from prison into the community and, because of their mental illness, commit an offence and go to prison and not into hospital.

*(*Lord *Glenarthur).* I have given you an example of what I am trying to do about it——

1306. With respect, I have every admiration for what you are trying to do personally, but that at the moment means very little.

*(*Lord *Glenarthur).* If you would allow me to develop the theme a little, I would be able to explain. First of all, I think one has to accept that there is probably an irreducible minimum within the prison system at any one time, of those who can be put into another sort of institution, whether it be a mental hospital or whatever. There will always be those, however much we dislike the fact, who are untreatable in some way or another. I would not—I could not—put a figure on it because I do not think anybody could; it would vary from time to time. For those who are within the prison system as prisoners and who leave who have some sort of mental instability, I do think there is scope for improving, for example, the through-care which the Probation Service can help with. That would have to be conducted in conjunction with social services, no doubt. That is a direction which we are going to develop and which, as I tried to indicate, will form part of the initiative which I am very keen to develop at the moment. The other aspect is that medium and secure places within the National Health Service are growing. I think the last time I answered a question 10 out of the 14 regions now had regional secure units, and interim secure units if they had not got the regional secure units. At the same time the DHSS are taking forward an initiative concerned with the difficult-to-place patient because, of course, some of those are the sorts of people who may commit some crime and ultimately be sentenced to a period of time in prison and then might go

[Mr Winterton *Contd.*]

out of prison in the way you suggest, then fall foul of the law again because facilities in the community for looking after them are inadequate.

1307. Would you not therefore, Minister, slow down this discharge of patients from psychiatric hospitals into the community until there is adequate accommodation and professionally qualified skilled supervision to ensure that people who are mentally ill and commit offences because they are mentally ill—not because they are criminally inclined—do not get discharged unless there are places where they can have refuge and be looked after other than in prison, which is increasingly the situation. There is a growing prison population of those who have been discharged from psychiatric hospitals into the community and then those hospitals perhaps are not prepared to take them back again when they do offend because of their mental illness, not their criminal inclination. Are you not prepared to do something about it and fast, because there are some of us in this House who are deeply unhappy and concerned about what is happening?

*(*Lord *Glenarthur).* I think you are right to be deeply unhappy about it, but unfortunately in an imperfect world you simply do not achieve these things overnight. I think the policy of the DHSS, which is something I have to say I entirely support—developing care in the community, closing down some of the large psychiatric hospitals—has to go hand in hand with what we are trying to develop—that which I have just described—so far as prisons are concerned. I have already appeared in front of your Committee once with Kenneth Clarke to answer questions on this issue and I know what an interest you take in it. I take a very close interest in it too, but I am quite certain we have to move in parallel with what is being developed.

1308. That is exactly what is not happening. You are discharging them and there are totally inadequate numbers of people with skill and qualifications in the community to look after them and totally inadequate accommodation. Will you not—I put this question to you directly—in fact seek through your influence in your position to slow up the community care programme and policy until there are adequate facilities to cater for those people in the community so that you do not fill your prisons up with them unnecessarily?

*(*Lord *Glenarthur).* I can assure you that, if this is going to be taken forward in the way that I want it to be taken forward, the DHSS will be very closely involved in it. That is my intention and I have no reason to believe this matter will not be one of those taken into account in what we are doing. I think you also have to bear in mind, although I know you have very strong views on this issue, that the care in the community effor is improving and I do not think you disagree—I hope you will not disagree—tha most professional advice I have come across in both worlds—I am sure Dr Kilgour wil bear this out—does agree that care in the community, notwithstanding the difficul gap over the development of resources i the community, is the right way foward fo most of the people who up till now hav been contained in these large institutions.
Mr Winterton: I think there is a changin view amongst the professionals.

Chairman

1309. We will not pursue that. It is nc the Minister's responsibility at the presen time and you are being a little unfair to him we would not wish to be that.

*(*Lord *Glenarthur).* Thank you very much

1310. Arising out of the response yo gave to Mr Kennedy about the lack o research into the needs and numbers o mentally disordered inmates in prison, wh do you not respond more enthusiastically t these proposals because there is obvious very considerable need for research to b done into the condition of those people wh come into prison and they way in whic they deterioriate? Ought you not be be mo interested either in supporting researche who want to deal with this or in initiatin reseach of your own in order to get mo information about this particular group o people?

*(*Lord *Glenarthur).* I think it is essential t follow through with research. Dr Kilgou with his specialist knowledge might like t comment.

*(*Dr *Kilgour.)* I can say, Chairman, this probably the most important bit of researc we now need to do. Our snapshot in Decem ber was a crude, rough managerial nee which we required, but we need somethi far more done in depth. A research proje on these lines is in fact at this preci moment ready to go out. We are invitin some well known academics who may we be not unfamiliar to this Committee——

1311. Within a stone's throw, you mig say?

[Chairman *Contd.*]

*(*Dr *Kilgour.)* You might say—in the very near future we are inviting them to come in. The project in fact has been being shaped in the last three months and it will be out. The idea is to commence work at the beginning of the next academic year, October of this year.

Chairman: We would be very interested to see the result of that and, of course, to support it in any way we can. Can we refer to that in our report?

Mr Favell

1312. On this question of research, the Minister will probably remember soon after he was appointed I raised with him a very unfortunate case involving two of my constituents who were murdered by a man within a fortnight of his being released from prison under the most bizarre circumstances; he was quite clearly mentally ill. I do not know if Dr Kilgour is acquainted—he probably is—with the recent research by Pamela Taylor at Brixton who has found of those on remand for serious violent crimes—just on remand—something like three times as many were suffering from schizophrenia as one would normally expect even among people in the prison population. At the moment as I understand it, the only real in-depth examination by a psychiatrist of somebody who is in prison either on remand or convicted for a violent offence, is if they happen to be remanded for medical reports. Now, this leaves an enormous gap because not everybody remanded to prison is necessarily remanded for medical reports, of course. Certain people are convicted without having been on remand in custody at all. Would it not be wise for every single person who is convicted to undergo a psychiatric examination soon after conviction, one, to find out whether they are suffering from mental illness in view of Pamela Taylor's research and, two, to ensure that they get treatment whilst they are in prison rather than some time later when they may be untreatable or may have committed further offences?

*(*Lord *Glenarthur).* I must say I do think there would be enormous practical difficulties to examine every individual that may have been convicted.

1313. Of violent offences?

*(*Lord *Glenarthur).* I think there would be difficulties for that too. I sometimes find it a pretty narrow line to draw between those who are violent, and a pretty fine line to draw between those who are violent and apparently sane so far as the Mental Health Act goes, and those who are violent and insane. I think the layman's view might be that anyone who commits some sort of violent act is in some respects not normal. I do not know how far you can take it to the degree that you suggest. I think there has to be a clinical sign—those might be the words Dr Kilgour would use—some clinical evidence that a particular mental state did exist. He would be able to develop that.

*(*Dr *Kilgour.)* I can only add that it does not require—and my psychiatric colleagues in the room will forgive me—it does not require psychiatrists necessarily to spot mental illness. Every inmate going into prison for whatever offence receives medical examination and, of course, any signs to a doctor of any kind of bizarre behaviour——

Mr Winterton

1314. What level?

*(*Dr *Kilgour.)* It depends on the examination.

1315. Is it not, from Mr Favell, this medical examination which you refer to?

*(*Dr *Kilgour.)* The first examination on his reception would be. Any signs of bizarre behaviour will end up with an inmate being reported, if not only by staff but by fellow inmates, and he will end up coming before the medical officer with some kind of complaint, or by others, about his behaviour. As soon as the medical officer sees this, I would expect any normal professional doctor to call in psychiatrists to deal with what would be a psychiatric problem.

1316. What is the extent of that?

*(*Dr *Kilgour.)* At the moment on the snapshot we have, and these are preliminary figures, I would have to say it would be something of the order, in the sentenced population, out of 30,000–32,000 male adults, of something like 1,500.

*(*Lord *Glenarthur).* If I can say too, that it ties in the need for everyone concerned to keep a very close eye on people and this ties in with the question of suicides. It is not dissimilar sort of behaviour demonstrated by those people and must be closely looked at, not just by the doctor concerned.

1317. Do you not think Mr Favell's suggestion does conflict, that violent offenders *should* be examined by qualified professionals to see whether there is in fact a mental illness or personality disorder behind what they have done so that the appropriate

[Mr Winterton *Contd.*]

treatment can be implemented, as Mr Favell has quite rightly suggested to you, during their imprisonment to prevent further offences?

*(*Lord *Glenarthur).* I share everyone's concern about violent offenders. I have to say, I do not think in a great many cases that they are, in any case, suffering from mental abnormality; a lot are plain evil. You would have to go the whole way back to almost rebuild a man's life, not just from the point of view of any mental incapacity of a clinical nature, but go deeper than that. I do not think that is strictly the answer. I do not believe that it would be practical because of the amount of resources, in the widest possible sense, that can be devoted to it; but I do think that there is a case for continually reviewing the whole system of looking at people who present these extraordinary forms of behaviour and the science on it is developing the whole time.

Mr Favell

1318. I think then he does not know about the research which shows a remarkably high incidence of schizophrenia among these violent criminals?

*(*Lord *Glenarthur).* That is probably right. In my narrow experience, I think that it goes back to what I originally said—a lot are plain bad; whether they are bad before they are mad is a difficult judgment.

Mr Winterton

1319. Dr Kilgour has given us some reassurance, having in the last 24 hours commissioned some research. What about the independent research that could be available to the Home Office, would he not consider funding other additional research from independent sources from experts who may well be able to provide the necessary information to the Home Office in this area?

*(*Dr *Kilgour.)* If I could give an answer to that. I would not like to give any impression that there is any block in the desire to get more knowledge of this. If any particular points of recent research points to the need for further research, this is done. There are in fact at the moment two other areas for research which will come up, pieces of work needed to be done at Grendon. While members of the Committee may well feel an awful lot of things take an awful lot of time, there is in fact progress coming out of this and will be some more research projects related to psychiatric problems in the course of this.

1320. I am advised that a number o people have come forward to do, what the would consider to be, excellent projects an have not been permitted to do so by th Home Office. Is that correct?

*(*Dr *Kilgour.)* The phrase "excellent prc jects" is a subjective judgment. There ar some times when resources are not alway available; sometimes for security reasons risks in carrying out particular kinds c research. I can think of areas outside th psychiatric side, for instance on AIDS where there are ethical reasons for not doin something; from a scientific point of view i is desirable to do, but wrong to do it becaus there are other considerations to take int account. If there are particular issues whic the source of your advice may wish to raise I am quite certain it would receive sympathetic hearing.

Mr Favell

1321. On a slightly different aspect, som people do feel that the medical observatio facilities in prison hospital should be in proved for those who are remanded i custody for medical observation. Are yo happy with the situation as it is at presen

*(*Lord *Glenarthur).* You mean the cond tions between hospital officers, the docto and the prisoner concerned?

1322. Facilities which are necessary i order to draw up a proper report for th purposes of sentencing a prisoner?

*(*Lord *Glenarthur).* This is in the realms o the technical side.

*(*Dr *Kilgour.)* The answer must always b that I do not think one can ever be satisfie with existing conditions, even if they we perhaps better in some cases than they are think that facilities are really stretched those very busy establishments, that is th local prisons and the remand centres, whe an immense amount of good work is don My criticism would be that they are oft under very great pressure and overcrow ing, which is going on at the moment. would be foolish to ignore the effect of tha The last point is that it harks back something the Chairman was talking abo earlier on, that the courts are beginnin slowly, to use more and more of tho provisions of the Mental Health Act whi allow them to remand to hospital rath than remand in custody; the more that c be encouraged, the better. It is not answe ing the question directly, but we can im prove on it; but the real factors at t moment are not so much the actual enviro ment and facilities available but the oth

[Mr Favell *Contd.*]

pressure upon them, and that is the overcrowding element.

1323. Turning to convicted prisoners now, where a severe disorder is discovered but where they may not be mentally ill within the terms of the Mental Health Act, do you feel that you are able to manage these severely disturbed prisoners adequately now and have you considered establishing special units like the one at Barlinnie for severely disruptive prisoners?

*(*Lord *Glenarthur).* Can I come in on that? The Barlinnie unit is not one I have yet visited. It is a highly specialised unit and I am told it is a very great success. It has already been arranged that I go and see it quite soon. We have already opened up one wing at Parkhurst to cater for the very difficult people whom you talk about. I think it is something we must keep an eye on to try and develop other facilities elsewhere. Grendon is a particularly good facility; I have seen it there. It is, of course, one that can really only best be used with somebody who is a properly treatable person. I think we come back to the difficult area, the core area if you like, of those who are not treatable and are not treatable anywhere, and I am afraid that, realistically, I do not see the end of the day when there is nobody of that type within the Prison Service. Nobody wants them and it is very, very difficult area. I do not know how we take it forward, but we have continually to turn our minds to——

Mr Kennedy

1324. A very quick supplementary on that: I am interested in the special unit at Barlinnie which has got this reputation. It has had a lot of books written about it, apart from anything else. One of the points that one of the prison wardens made to me—I know this is slightly outside the medical side but I wondered to what extent you might be able to offer comment on it for interest —was that that kind of unit disturbs the rest of the pretty tough prison population, that section of the prison population which is in for hard crime, because if they assault an officer or something like that they actually increase their chances of getting into this comparatively palatial special unit, whereas if they keep their noses clean and stay out of trouble for parole reasons, they have to serve out in a dingy cell in Peterhead, to take the Scottish context. Perhaps it is not fair to ask you if you have not been there.

*(*Lord *Glenarthur).* I have not visited but, if I can volunteer an answer to that, there are bound to be those who do try and buck the system. If you have a system which can cater for people like those that would go to Barlinnie, obviously one or two will try and buck it at some point. It happens in every walk of life, I do not see that this should be any exception. What I do think is important though is that we do keep abreast of developments like that. They tend to hit the headlines because a particular character has achieved great success there. That is all to be welcomed. I just wonder whether Dr Kilgour might help a bit more; I think it is still going to be an area which is fairly small.

*(*Dr *Kilgour.)* There are two points, if I may just add to that. First of all, I think it is important to realise Barlinnie is not designed for treating mentally disturbed people; that is very important. Barlinnie is a control unit for dealing with control problems: it is really something quite different. Mr Favell's point would give a further answer to this. I think we are beginning to see more clearly. If we find we have about 200 to 250 people who are mentally disturbed and perhaps a further 50 or 100 who are mentally handicapped, we could very well meet these needs by picking individual establishments of the appropriate category —male, female, young offender and so on —across the country, and we would then perhaps use this as a factor for allocation in the future. We would make sure the sum of the staff in these establishments contained an appropriate number of either Medical Officers—no extras, just making sure those on the staff had psychiatric qualifications —or Registered Mental Nurses among the hospital officers so when people were in that establishment there would be no separate unit or anything like that and there would be people on the staff capable of giving them special attention which they might need.

Chairman

1325. What progress has been made in improving the C1 unit at Holloway since the Holloway Special Project Report was published?

*(*Lord *Glenarthur.)* There are two aspects of development of C1. One is the new unit which will be built immediately. There is work being carried out on bringing certain improvements into the existing unit at the moment. I think I am right in saying four cells have just about been completed. We are trying to take four out at a time as opportunities allow and the work that is going on in them consists of, first of all, removing the blind spot which existed

[Chairman *Contd.*]

where the lavatory was; secondly, recessing the radiators; thirdly, replacing the floor covering; fourthly recessing the light, and generally bringing them up to the sort of standard they ought to have been at. At the same time, one of the noticeable gaps in C1 was a special room to cater for those who were most disturbed. Work is going ahead for the development of that. There are one or two other physical things to do with the staff facilities on the wing and then, away from the physical side, there is first of all the appointment of a Senior Medical Officer to manage that wing which I regard as a very important aspect of it, and in due course too the appointment of a Principal Medical Officer to be at Holloway. So the work is going ahead and is going ahead now really quite well. I visited about a couple of weeks ago myself and saw it there. There is also a Portakabin type room which is going to be moved properly later on in the year within the planning scale to allow association and things like that to take place under better conditions than possibly exist.

1326. That is urgently needed.

*(*Lord *Glenarthur.)* That is urgently needed, I quite agree. I must say the design of Holloway C1—and not just C1—is pretty ghastly.

1327. It leaves much to be desired?

*(*Lord *Glenarthur.)* It does leave much to be desired. Anyhow, we have got it and I think we have got to make the best of it and make improvements in the interim to C1 before the new unit is built.

1328. When do you expect the improvements to be completed?

*(*Lord *Glenarthur.)* By the autumn. Late summer, I think August.

Sir David Price

1329. Could we move on to drug and alcohol abusers? Many prisoners have complained of lack of follow-up after release and they have been prisoners who have had a drug or alcohol problem. On the 29th November your Department announced its intention to withdraw financial support for detoxification and alcohol rehabilitation centres. Is this not a little shortsighted?

*(*Lord *Glenarthur.)* I am not familiar with that particular announcement, I am ashamed to say. Perhaps I can say that one of the areas in which we have got to take forward a sensible initiative on this is the through-care side of those who have been on drugs when they came into prison and then leave and possibly go back to that world. It does seem to me there is a great difference in the approach that we have in prisons because obviously the treatment of somebody who is in prison is different from that in a normal detoxification centre because we do not use methadone and things like that to that extent. There are those who say it is a good thing and it works. I do not have the experience on drugs that David Mellor has, for example, in this particular field. But the idea that we should provide a through-care service to look after them if taken forward with speed is something we will continue to develop.

1330. In the reply from mainly the DHSS, but I think also your Department had an input into it, to our report of the previous session on misuse of drugs it was said—and this is clearly your Department and not the DHSS—that you had some 20 projects in receipt of financial support from the Home Office in which there was residential care available for ex-offenders with drug problems. Possibly to save time you could just let us have a note on that.

*(*Lord *Glenarthur.)* I can certainly let you have a note on that. I do not have details with me.*

1331. I gather from what you said that your Department took slight exception to our criticisms and the fact that we got the fairly clear impression that not enough was being done, either in prison or in follow-up afterwards on ex-prisoners, and this was, I think, quoted as part of the evidence, that your Department thought we had got it wrong and that, in fact, as a Department you were doing a great deal more than you thought we had given you credit for.

*(*Lord *Glenarthur.)* Can I take up your offer.

1332. I gather you agree with the thinking behind our criticism, namely, it is not sufficient to detoxify somebody, whether alcohol or drugs, but it is important to have the follow-up, and from the evidence we have got across the board, the former is relatively easy; getting a person permanently off that habit for life is inevitably harder?

*(*Lord *Glenarthur.)* Yes.

1333. It is the latter really that we as society have to concentrate on now?

*(*Lord *Glenarthur.)* Yes, I entirely agree.

*See Annex, Note 2.

[Sir David Price *Contd.*]

that is why I described that we do believe, through the probation service, the through-care facility should be developed, and that is what we are looking urgently at.

Chairman

1334. Can I ask what your policy is concerning mother and baby units in prisons?

*(*Lord *Glenarthur.)* We have a number of mother and baby units.

1335. We visited Styal which we found rather impressive, and Holloway.

*(*Dr *Kilgour.)* The whole problem of mother and baby units is bedevilled—one of the principles has to be that prison is not a good place to have children, having to bring children up. It is only when it is inevitable that the mother and baby should be together when the mother cannot be held anywhere else. Every factor is taken into consideration—if she is capable and she wants to, and some do not. The numbers of units that we have are provided, I think, on the basis of not an over-generous provision but they are in numbers and places where they are most likely to be able to cater for the expected need; some in the north and some in the south. An attempt is always made to try and involve as many NHS specialists about the back-up care of the units as possible. I think that if you have seen Styal and seen Askham Grange and the remarkably small unit in Holloway—

*(*Lord *Glenarthur.)* Can I say at this point, I am well aware that concern has been expressed on this issue. What Dr Kilgour said originally about prison not being a suitable place for babies is a very sound point to make indeed. The other side of the coin is that mothers should not be separated from their babies. I fully understand that. There has been a call for independent research being commissioned in this field to try and study the physical and psychological development of babies during the time that their mothers are in prison, indeeed, not just in prison but also when they have left prison, to see how that development is affected. What we are going to add is to start research which will begin in March this year—it has started, with any luck!—that will compare those mothers who are not subject to this experience with those who actually have suffered it.

1336. Where is the research being carried out?

*(*Dr *Kilgour.)* In three establishments; two at Askham Grange and Styal and I am not sure about the third.

*(*Lord *Glenarthur.)* We can let you know the third.* It will provide a pretty useful independent evaluation of just where we ought to go on this rather difficult matter.

1337. We found the set-up at Styal interesting and constructive, if I may say so, and the buildings were in very good condition. It was a complete contrast to Holloway.

*(*Lord *Glenarthur.)* I have not myself visited Styal, no doubt I will in due course. I am very encouraged to hear what you say.

1338. Quite constructive work was being done. Do you not think that the few mothers with young babies should be released on parole is an idea worth considering?

*(*Lord *Glenarthur.)* So much depends upon the individual circumstances. I do not think one can generalise. I think that to go down that road is going, to some extent, along with the idea held in the late 1960s and mid 1970s that perhaps women ought not to be in prison at all. It is a difficult area. Circumstances have proved that there are those who ought to be in prison and not on parole; if they have babies it is most unfortunate. It is better to take the research forward that we are doing and find out exactly the present situation. I do not think it is realistic to suggest they should be on parole, it depends on the circumstances.

1339. Perhaps you can be more relaxed towards certain women, depending on the offence?

*(*Lord *Glenarthur.)* It is a matter for assessment by those who look at it, the courts and all those concerned.

1340. And how they develop during the course of their time in prison?

*(*Lord *Glenarthur.)* Whether parole is quite the right mechanism is purely a matter for people to give thought to. I do firmly believe that one could not suggest, just because people had babies, they should not be confined to prison. That would be a very serious mistake.

Mr Galley

1341. We had a strong plea to the Committee recently for the abolition of Crown immunity in prison hospitals. There was a written reply recently which suggested you had no plans to do this. Does it not seem to be nonsense to say, "We are going to abolish

*See Annex, Note 3.

[Mr Galley *Contd.*]

Crown immunity for the NHS hospital and not the prison hospital"?

*(*Lord *Glenarthur.)* No, I do not think it is the same. I think the most important thing is to develop a very close link with the environmental health officers locally; and the prison medical officers can invite the enviromental health officers to come in and see what is taking place so that their advice can be obtained, should it be needed. I myself do not believe that just by ending Crown immunity—and there are all sorts of legal matters within the whole system of Crown immunity—you end the odd case of food poisoning that may occur. I know of lots of examples outside any prison in the public world where it does nevertheless arise. We all do. I think that it is a question of the outcome that you want to achieve. Prison hospitals and prison kitchens are all subject to the sort of inspection described earlier. They are impressive in their quality in lots of different ways. There are security aspects to be taken into account inevitably in prisons as well, but one is not hiding behind security aspects. I believe at the end of the day the answer is to develop a rapport with all those concerned and encourage them to come and see what we do.

1342. Subject to the security aspects being dealt with, what have you to lose by removing Crown immunity?

*(*Lord *Glenarthur.)* First of all, I think Crown immunity is a live issue within Government at this moment as a result of the DHSS decision to end Crown immunity for hospital kitchens. The two are not really comparable. They are subject to different forms of inspection, and in my experience and Dr Kilgour's experience too, I am sure we will both agree and tell you, that the standards that are maintained are excellent, and that it is important to establish the right contacts within the environmental health world to encourage them to see what we are doing is perfectly above board and to a very, very high standard indeed. There are legalistic and other problems associated with Crown immunity and, as I said, it is a live issue. I do not think I can go any further than that.

1343. Do environmental health visitors have any right to ask to come into prison hospitals and kitchens, or is it just a matter of invitation?

*(*Lord *Glenarthur.)* They do not, but what is surely important is the outcome. If the outcome is close collaboration between all those concerned, that is what we strive to achieve.

1344. But if the facilities are excellent, it would surely be quite reasonable for the environmental officers to have the right of entry, suspicion of anything wrong would be overcome very easily.

*(*Lord *Glenarthur.)* Well, if they are coming in anyway, then they are seeing it and going away with a perfectly clear idea of what—

1345. They do not have the right to come in.

*(*Lord *Glenarthur.)* As I said, the right is one bound up in the legalistic argument which involve other aspects of Crown immunity which go wider than just prison hospitals and prison kitchens. The DHSS have taken a view; I do not honestly think I can go further than that. I take the point you make. I think what is quite clear is the end result we are looking for. The environmental health visitors who visit the prisons I know of have found the conditions to be perfectly satisfactory.

Sir David Price

1346. Can we come on to the problem of infectious diseases? Are you confident that the prison hospital facilities are adequate for nursing prisoners with infectious diseases? I ask about barrier nursing, for instance.

*(*Lord *Glenarthur.)* Infectious diseases, AIDS, hepatitis and so on, are of course very live issues and present a great deal of concern and an awful lot of uninformed comment. We have already planned a unit at Brixton to meet the particular concern that infectious diseases within prisons brings forward and that is being taken ahead. There are differences between the needs of, for example, somebody with AIDS or not with AIDS but with the antibodies found in their bloodstream, and those who actually have developed something like hepatitis.

1347. But you mentioned AIDS. Can we ask more about it? How seriously do you take it? We have it on the authority of the Medical Reseach Council that in their view—and I quote them—the numbers are doubling every eight months and if the spread of the virus were stopped now the number of cases would double every year until 1988, with its incubation period.

*(*Lord *Glenarthur.)* I can tell you that AIDS is a very serious matter. I do not think

[Sir David Price *Contd.*]

anybody says anything other than that. Indeed, it is one which the Government in its widest sense recognises and there is in existence at inter-departmental group to look at it in its broader sense. Statistics are bandied about from time to time. Whether those particular statistics are valid I do not know. Dr Kilgour might like to comment.

*(*Dr *Kilgour.)* It does appear at the moment, without diminishing the actual statistics, that the curve is flattening out, but it is still very serious and those points which you made—that it will double periodically until 1988—are certainly true.

1348. Then what provision are you making? It seems to me there are two aspects of it: there are those who actually develop AIDS, and there are those more positive people with the HTLVIII, of whom one understands of the order of between 10 per cent and 20 per cent may develop it, but a lot obviously will not.

*(*Lord *Glenarthur.)* There is a lot of concern expressed by those who work in prisons, prison officers and others, that just because somebody has the antibody they are a source of great danger to others. This is not the case. I think there is a very great deal of education to be done here and I have come across instances myself on visits where I have been approached by the prison officers who have really been over-concerned. It is right that they should have the concern but they have been filled with such unwarranted horror that they are at very great risk of catching AIDS. There is a very great need to educate the public here. The DHSS has already started a campaign which is being developed and certainly the Prison Department is with them.

1349. With respect to you and the general issue, surely in a confined population this is a very much more serious problem in regard to what people believe to be true as against what is true and the fears are far greater, I suggest to you, than they are in society at length. I expect it is more when one is in a ship than in an ordinary town, and even more in a prison where people are confined.

*(*Lord *Glenarthur.)* I think that is right. That is why I think there is great need to educate all those concerned to understand what those risks are. The risk—

1350. What are your Department doing about that?

*(*Lord *Glenarthur.)* Precisely that.

1351. How?

*(*Lord *Glenarthur.)* We have involved, for example, the St Mary's Hospital experts; they are providing an in-house course which starts next month to try and take forward concern on this.

Chairman

1352. Who is the course for? You say in-house?

*(*Lord *Glenarthur.)* For people within the—

1353. Prison officers?

*(*Dr *Kilgour.)* The main body of the people who will be on the course will be psychologists, full-time psychologists in the Prison Department. As a result of the discussions within the prison Department we decided obviously we needed a full corps covering the whole of the country of expertise for counselling not only those who were full-blown cases of the AIDS syndrome but those who were HTLVIII positive. So we have been sending members of the Prison Department, Medical Officers, hospital officers, psychologists and a couple of chaplains on the course at St Mary's. During April they will be having a complete course for ourselves so by the end of April we should have something like between 50 and 60 people who will be, one would say, expert at counselling and able to cover the whole of the——

1354. Surely the most important people of all, given the nature of this problem, must be the governors?

*(*Lord *Glenarthur.)* Yes, they are linked in with it.

1355. I wonder whether you could between you let us have a short paper on this as to precisely what you are doing?

*(*Lord *Glenarthur.)* Yes, we certainly can.* It is a very great deal and it is——

1356. Put it down.

*(*Lord *Glenarthur.)* I do not want you to allow me go without saying there is absolutely no complacency on the part of anybody involved with AIDS that more cannot be done. There is a very great deal of education to be carried out throughout. This has become quite clear to me when I have talked to prison officers who come out with the most amazing ideas about what might happen, and just because somebody has an

*See Annex, Note 1.

[Chairman *Contd.*]

antibody in their blood they are put in a room and people will not go anywhere near them. If you can bring the experts down to talk to them—we have done that on numerous occasions; we had them at Ashford not long ago—the people concerned are reassured.

1357. You need to have very explicit explanations about the possibility of AIDS arising from homosexual behaviour within and outside prison.

*(*Lord *Glenarthur.)* Absolutely.

1358. That is the main message.

*(*Lord *Glenarthur.)* That is a very important message. The Health Education Council leaflets are available anyway and there is a very, very great deal of collaboration with the DHSS in the wider initiative of the group now looking at it.

*(*Dr *Kilgour.)* I have one very quick point about governors having to understand the disease and its implications. That is absolutely right, but in terms of counselling a governor is not really the sort of person one would expect the patient to discuss with or turn to for professional advice.

Sir David Price

1359. I was taking it across the board. I had a meeting just last week with the people at St Mary's and St James and a number of others who are concerned generally as to how slowly the message is getting across and who are coming to us and asking what we could do to help.

*(*Lord *Glenarthur.)* I think we all have a part to play in it. It is one being taken forward within government generally and it is gathering pace. It has to be managed carefully, there is no doubt about that.

Mr Winterton

1360. I think we must press on. You have just talked about delay—we have received many complaints about the slowness of decision-making within the Home Office. We have been told, for example——

*(*Lord *Glenarthur.)* Decisions on what?

1361. I am just about to give you examples. For example, that it takes the Home Office up to six months to vet candidates for doctor and nursing posts within the Prison Medical Service. It has been suggested too that the Home Office takes so long to agree to the releases from secure hospitals of patients under restriction orders, the NHS doctors are unwilling to accept patients from prison under restriction orders because they fear their beds will be tied up for an unnecessarily long period. What are the reasons for these delays and what are you, as a relatively new Minister within the Home Office, seeking to do about it?

*(*Lord *Glenarthur.)* May I answer the second one first. The first question is one which I might ask Dr Kilgour to answer, it relates to restriction orders on those from secure mental hospitals and this is something which I have been on the edge of now for about three years and it is an exceedingly different area. There are those, and you know as well as I do, who would say that you should not let any of these characters out because they are extremely dangerous people. People fail to understand a great many non-restricted and restricted people are released from secure mental hospitals and never ever return because everything goes swimmingly, and there are a few that go wrong. It is a very, very difficult decision for individuals to take. At the end of the day these individuals who have to take decisions about whether or not a man is right to be released—David Mellor does this and know from personal experience dealing with him in the DHSS, that these are some of the most difficult cases he has to deal with.

1362. Do you think the long delays in dealing with these particular inmates/patients are justified because of the sensitive nature of their crimes and what they may or may not do?

*(*Lord *Glenarthur.)* I think that is part of it. The other side is to ensure that if they are leaving the secure hospital to be phased, so to speak, into the community through, for example, a regional secure unit and appropriate services are available in the community for them to be attended to and given them the care they need to re-establish themselves in society, this also accounts for some delay. The delay is, I think, a very difficult one to get round. I think the important thing at the end of the day is that those who should be released, if they are non-restricted people, should be so.

1363. What about the first point, namely the time it takes to vet doctors and hospital staff?

*(*Dr *Kilgour.)* There are two or three points to make. First of all, that as the employer needing to get people into posts I am greatly concerned with speeding the process up. When I first arrived I shared the critical thought that lies behind your question. I would say at the moment, no

[Mr Winterton *Contd.*]

defensively, but the number of occasions on which three to six months is occurring as a delay is decreasing very much. There are some times when it must occur. You put an advertisement in the paper; you have a sift of the paper qualifications and then the interview. If they are successful candidates are handled by the Civil Service Commission and not the Home Office to the stage of being passed through security grading and then this accounts often for those delays now which occur, shall we say, more than six weeks after the interview. When we get the all-clear from the Civil Service Commission we offer them a vacancy, but we cannot get them into the post because, normally, if they are people of any value they are in employment and have to give three months' notice to their current employers. These are some of the reasons. We have had one-off and unrepeatable reasons in the nursing hospital staff in the last year, we had a moratorium on recruitment due to broad Prison Department policy at the time related to resource availability and this held up the process for a period of six months and there was a delay to recruitment. I am hoping that kind of delay would not occur again.

Chairman

1364. Does it take longer now than it used to?

*(*Dr *Kilgour.)* It takes less time now because, with each of the medical officers coming up, where there is a delay I have a bring-forward system: once a week I harry the Civil Service system.

Mr Favell

1365. On the topic of resources and planning, I have a fairly long question to start with. Could you tell us what the implications will be for the Prison Medical Service of the new local budgetary control system for the prison system. Will there be any earmarking of grants for the running of medical services in prison? Is it the Governor of the establishment, or the Regional Prison Medical Officer who will decide how many Hospital Officers or how many hours of Hospital Officer overtime can be budgeted for?

*(*Lord *Glenarthur.)* In general it is right that budgets should be devolved to the prisons themselves, and the system that is in existence is one of agreement between the Regional Director and the Governor of the prison about what that budget should be. The Governor, after all, is the man or woman who is ultimately responsible and will be spending that cash. The medical side comes within that overall budget at the prison. The standards of medical care in a parallel way will follow down from the Directorate through to the Regional Medical Officer and down to the prison itself. Overall there is no earmarking as such but standards must be maintained within the whole web of systems that we have described in answer to earlier questions; but the bulk will be decided at the prison itself with the agreement of the Regional Director.

1366. Several witnesses have suggested that the budget for the Prison Medical Service should be entirely separate from the budget for prison services generally. What are your views on this? I can anticipate your answer.

*(*Lord *Glenarthur.)* I do not share that view. I think the Prison Medical Services form part of the overall aspect of how we treat and look after people who are ill within the prison; it falls within the full system. There is no need to specially earmark for that; the system is managed and arranged and will be agreed with the Regional Director. That is the way to take things forward.

1367. Perhaps Dr Kilgour can answer this. Do you anticipate there is going to be any conflict at all, and if so, how is it going to be resolved?

*(*Dr *Kilgour.)* The first answer is, in all good management situations with restricted resources there are always going to be conflicts. It is all choices and options. In answer to your question, and this reinforces what the Minister has just said, very rightly, I do not believe there is going to be any change in the ministerial position which has been kept very clearly over the years, which is this: that there will never be a situation where an inmate is considered to require certain treatment or certain consulting, a second opinion or certain medicaments and not be treated because of lack of resources. Resources will always be found for what are legitimate professional judgments of what the needs of the patient are. There is one centrally important fund, which is the fund for buying pharmaceuticals, kept centrally by my Directorate, and if one prison establishment is running out of funds, in order to be able to buy essential drugs further funding will be provided.

*(*Lord *Glenarthur.)* If anybody needs treatment that cannot be provided within the prison service he goes into a national health

[Mr Favell *Contd.*]

hospital as anybody else would. It is a separate part of the system.

Chairman

1368. It has been suggested to us that funds have been diverted from the Prison Medical Service to the Prison Building Programme, is there any truth in that?

*(*Lord *Glenarthur.)* No.

Mr Favell

1369. We see from the papers that you have sent us that that the post of Director of the Prison Medical Service is graded as Grade 3—Under Secretary. Are you satisfied that this grading is appropriate given the responsibility involved?

*(*Lord *Glenarthur.)* I have the Director next to me. I think this is a matter on which it is very difficult for me to answer with Dr Kilgour being here but——

1370. Shall we send him out?

*(*Lord *Glenarthur.)* No, no he can stay. The grading of people is within the whole Whitehall open structure, as I believe it is technically termed, of grading and it is a live issue there as to whether it is right or wrong. Dr Kilgour is a very, very excellent Director of Prison Medical Services, I can tell you that. Precisely what the outcome will be of the current review of this I cannot tell, but I have a vested interest in having an excellent Director of Prison Medical Services.

Chairman: I realise it is probably not within your gift but I do not think we have given too much away by saying that we have heard a great deal of praise for Dr Kilgour and what he has achieved since his appointment.

Mr Winterton

1371. He will quote that in support of any application!

*(*Lord *Glenarthur.)* I am very grateful for your remarks.

Mr Favell

1372. Have you any plans to increase the number of staff in the Prison Medical Service to allow the Principal Medical Officers to spend more time actually visiting prisons?

*(*Lord *Glenarthur.)* That is a question best answered by Dr Kilgour.

*(*Dr *Kilgour.)* The short answer is no. There is always, I think, an opportunity for managing staff time better than we do do. The Principal Medical Officers are finding a great deal of over-charge on their desks at the moment. This is principally because there are three bits of their work: one handling the day to day crises in the normal manner—I think three is par for the day, as it were. The second is to handle support subjects which they take, things like nutrition or young offenders policy, broad subjects like that. They have to deal with these things and it takes an immense time to handle. The third thing is the very important business of getting round the establishments and visiting. They do have programmes for doing this and they do visit some more frequently. They are scheduled to visit the larger establishments more frequently obviously than the smaller establishments but I reinforce this myself and go round. I have been round 93 of them, some of them as much as ten times—those are the ones which require much more attention. We do get around them all. I wish we could do more than we are doing at moment. I think the balance is roughly right but it will never be perfect.

1373. Has the head of Nursing Service got enough support?

*(*Dr *Kilgour.)* The first thing to say, if I may say it rather as the Minister did indeed is that he is an excellent Head of Nursing Services and the post I believe is considerably under-graded. We expect during the course of the next few months to have a grading review which will produce something rather more appropriate. When that happens he is then going to require more formalised support staff. At the moment it is done on an *ad hoc* basis and, thanks to the quality of the individual, the tasks do get done but I believe we will have to be more systematic in the future.

Chairman

1374. Why do you not when you are designing a new prison or making alterations to an existing prison consult the prison staff, the medical staff and the prison officers and nursing staff, those who are going to work in the prison? We found that Holloway was a very bad example of consultation not being carried out with many difficulties to cope with as a result.

*(*Lord *Glenarthur.)* To clarify the question, can I ask you to elaborate? What aspects of Holloway are you talking about? Those which were designed in the late 1960s and early 1970s as we agree, do not meet what we now believe to be the case. I am not sure your——

1375. General difficulties of supervising the inmates and knowing what they were

Chairman *Contd.*]

doing and so on. They complained that in certain areas they could not see what was going on. Well, the question is, why do you not consult staff at the design stage?

(Lord Glenarthur.) There is a great deal of experience in the Prison Service as a whole about design of prisons. Design of prisons does not stay still. Certainly I am not aware at all of any lack of input on matters related to design in the way which prisons should be managed by all those concerned, whether they be Governor grades or whether they be prison officer grades, or those who work in the prison hospitals.

1376. I do not remember whether you said you had been to Holloway.

(Lord Glenarthur.) I have been twice and I am going again shortly.

1377. Did they not put it to you?

(Lord Glenarthur.) I am not sure if you are making a comment or asking a question about any particular area of it. Are we talking about the re-development of C1, the new unit at Holloway?

Chairman: I think Holloway generally.

Mr Winterton: It is awful. Even if there was an input it clearly could not have been needed.

Chairman

1378. Supervision is very difficult.

(Lord Glenarthur.) I think that is wrong. This was in the late sixties and early seventies when the Holloway design came to fruition. That was very much on the idea that was being developed then that women should not really be in prison, they should be in hospitals. So Holloway was designed to be a hospital environment.

Chairman: Not a hospital, my goodness me!

Mr Winterton

1379. If it were a hospital it would be even worse.

(Lord Glenarthur.) But what I am telling you is fact, that the ethos that was trying to be developed for treating——

1380. Could we get this on the record. When was it actually built?

(Lord Glenarthur.) Can you let me continue my sentence? If you interrupt every time I always forget what I am going to say next. The point is that at that time all the best minds in the world, or in this country, who were developing thoughts about how women should be looked after in prison set about designing something which was more akin to a hospital than a prison. It was felt that this was a more appropriate way of looking after those who were going to be within its walls. Now that has changed over the years and we realise that it is difficult in lots of respects, one of which is the problem of manning when you have to have people being able to see up and down corridors, and that sort of thing. The concept has changed, we are stuck with the design.

Sir David Price

1381. Can you tell me whether nowadays, not back then, you use proper work study techniques in developing these inputs? I speak as a professional in this area. I find it is not sufficient to consult people because they tend to be very vague about what they want. Often they want a new concept. It is only when you do it in great detail, carrying out proper work study techniques that you find many professionals have difficulty in articulating in detail the improvements they want. So one always has to optimise. One can never maximise.

(Lord Glenarthur.) Improvement, I think, is one thing: re-design of new prisons is another. I would not have said, for example, you need to put work study people in to do the work that is being currently done in the existing C1 unit, but certainly the development of new prisons is coming along where work study in its widest sense, and in a narrower sense too, is certainly employed. The difficulty though is that ideas march on and by the time the prison has been built from the very initial concept to the point at which it is actually built on the ground, developments have taken place in the way in which people think about these things. This applied at Holloway. It is part of the world we live in and it could happen again.

Mr Winterton

1382. When was it actually built?

(Lord Glenarthur.) It was built in 1973.

1383. You said the ideas in it were mid 1960s early 1970s and it was built in the mid 1970s.

(Lord Glenarthur.) I think it was.

1384. Why is there such an inflexible system that when, in fact, progress takes place and ideas change these ideas cannot be incorporated within an overall structure? It seems to me to show a total inflexibility.

(Lord Glenarthur.) It takes time to design and it takes time to build. I should think it

[Mr Winterton *Contd.*]

probably takes twice as long to build as it does to design. I agree with you, I wish there were a way of introducing greater flexibility. Once you have something stuck up in bricks and mortar it is damned difficult to change it.

Chairman: Perhaps we need some better architects.

Mr Winterton

1385. Can we suggest that?

*(*Lord *Glenarthur.)* Suggest what you like! I think that there is certainly scope for keeping alive all sorts of ideas and developing them for design. It is interesting to look to the American models of prison design. We put a few of these last summer, last autumn. I am going over to the States this autumn to have a look myself and see how those are developing. I think even those in the States who are very expert and come up with novel ideas, some of which we have started to use here, in some respects have had developments of their own ideals as this has gone ahead. It is very difficult when it is cast in bricks and mortar to change it.

Chairman

1386. Can I give you two examples of problems we encountered in Birmingham and Bedford where new "protected cells" have been built in at very considerable cost and medical officers do not use them; that must be a waste of money and something better could have been done?

*(*Lord *Glenarthur.)* I do think that the protected rooms, both within the special hospital scene and within the prisons, are not regularly used. I do think it is essential that protected cells are there.

1387. Doctors will not use them; they refuse to use them.

*(*Lord *Glenarthur.)* I do not know whether or not Dr Kilgour can add anything in those particular cases, those prisons.

1388. That needs to be looked at. There is a bit of research you can do there, because it is a waste of money.

*(*Lord *Glenarthur.)* They may have very good reasons, but what they are I do not know.

*(*Dr *Kilgour.)* It is not a universally-held view. You will find if you do a survey on the whole of the system, the majority of medical officers, who are in just such establishments, local and dispersal prisons, you will find something like two-thirds of the medical officers do, in fact, use the rooms a lot for very different purposes; a salutary change o environment; a lot do without them; som of them say that the mere existence of such room is sufficient to be—I will not sa deterrent—a factor in reducing bizarre be haviour. For a completely manic patient i may be another way of treating them.

1389. I am only saying what we wer told.

*(*Dr *Kilgour.)* In both cases—at Bedford i is the view of that particular doctor.

*(*Lord *Glenarthur.)* I went to Bedford th other day and found both protected room being used.

Mr Winterton

1390. Was it anything to do with you visit?

*(*Lord *Glenarthur.)* Not judging by the tw characters inside!

Chairman

1391. Were they new ones?

*(*Lord *Glenarthur.)* I cannot remembe whether they were new ones.

1392. We are talking about new pro tected cells built at considerable cost an not used.

*(*Lord *Glenarthur.)* If they were not bein used—I cannot honestly remember whethe these were new ones or not. If the old one are being used I cannot see why the ne ones are not.

Mr Favell

1393. With the one at Bedford there wa something wrong with the actual design, bi came off the wall or the ceiling. It was lousy design.

*(*Lord *Glenarthur.)* That is not satisfa tory.

Chairman

1394. It was not satisfactory for what was intended for. It could be damaged pieces could be torn off the wall.

*(*Dr *Kilgour.)* There has been a gre difficulty over the years to find a suitab compound to use which would be soft b stick on the wall too. With the latest desig it took one inmate 15 minutes to take if o with bare fingers!*

1395. The hospital at Featherstone, ov my constituency boundary, is underused

*See Annex, Note 4.

[Chairman *Contd.*]

we were told, but the new prison which is going to be built is going to have new hospital facilities. Why can the two prisons not share the same hospital at Featherstone?

*(*Lord *Glenarthur.)* I think in principle it is right—individual prisons should have hospital rooms of their own to meet whatever need it might be. I cannot give you chapter and verse on Featherstone.

1396. Perhaps you never thought of them sharing facilities?

*(*Dr *Kilgour.)* There is a piece of research work we are undertaking at the moment, operational research inside the prison department where seeking the best use of it we look at those establishments within the system and realise where we can conduct clustering of establishments, and there are three areas where we have identified it would be practical to consider clustering and the use of common users.

1397. Perhaps you could include Featherstone?

*(*Dr *Kilgour.)* It is precisely one.

1398. I apologise that we have kept you both so long. Thank you for your help, we are most grateful to you.

*(*Lord *Glenarthur.)* I hope we have been helpful.

ANNEX

Supplementary Notes by the Home Office

Note 1

AIDS

1. In developing measures to anticipate the threat it would face as AIDS spread in the general community, the Prison Medical Service benefited from the Director's previous appointments, his continuing contacts in the World Health Organisation (WHO) and the USA, and subsequent close liaison with DHSS. These measures were:

1. Education of the Prison Service generally:
2. Guidelines for medical officers and hospital officers;
3. Counselling for individual inmates;
4. Special training for medical officers and hospital officers;
5. Monitoring developments;
6. Provision of isolation facilities.

Education

2. The Medical Directorate has taken all possible steps to ensure that the Prison Service is kept informed of all aspects of the AIDS problem. Much of this work has been undertaken by the Director, Dr Kilgour, himself. He has given talks on this subject to the Annual Conference of Governors and the National Executive Council of the Prison Officers' Association, and has addressed Prison Officers' Association meetings in each of the four regions. In addition, when the circumstances have merited it, he has addressed mass meetings at several key establishments. The Regional Principal Medical Officers have also carried out similar work in their particular areas, organising meetings with both medical and discipline staff to ensure that staff are well informed about the nature of the AIDS condition and current policy on the management of cases.

3. Copies of leaflets designed by the Health Education Council, the Terrence Higgins Trust, and the Standing Conference on Drug Abuse (SCODA) have been sent to all managing medical officers.

Guidelines

4. A series of guideline documents has been issued to Governors and Medical Officers. They describe the nature of the virus, measures to be taken to prevent it from spreading and

the manner in which AIDS sufferers and potential sufferers should be treated an counselled. The guidance is revised as necessary in the light of the changing state c knowledge of the disease. Close contact is maintained with the Chief Medical Officer of th DHSS to ensure that the Prison Department's own information keeps abreast of wid experience. By disseminating guidance widely in establishments it is hoped that practice i the field will be both informed and uniform, and that understandable staff anxiety will b reduced.

5. To ensure as far as possible that the guidelines are correctly interpreted, Dr Kilgou has spoken to meetings of Principal Medical Officers and Senior Medical Officers in the fiel on three occasions about the underlying policy issues. The PMOs and SMOs are encourage to take every opportunity to instruct prison medical service staff and discipline staff on th subject as it affects local establishments.

Counselling

6. For individual inmates who may develop AIDS or are known to have been exposed the HTLV III virus, or are suspected of having been so exposed, counselling is provided v the Prison Psychological Services. To ensure that the maximum benefit is obtained fro their services, selected psychologists are currently attending special courses run by D Miller, Clinical Psychologist at St Mary's Hospital, London.

Special Training

7. The DPMS is alive to the need for a formal training programme. It is intended establish regional training teams in the necessary skills and knowledge to provide on-si training for prison staff of all grades and disciplines both on a regular, planned basis and response to *ad hoc* demand. To this end, a team from Oxford (including Dr Gallwe Clinical Lecturer, in G U Medicine, Oxford and Dr Miller, Clinical Psychologist, St Mary Hospital, London) has been engaged to run a seminar for potential trainers in May. Tean have been assembled from each region to attend the seminar. They comprise two seni members of medical officer grade staff from each region, together with a Hospital Chi Officer and a Discipline Chief Officer. A representative from each regional office, thr members of the nursing service and a representative from the Directorate of Psychologic Services will also attend. The team from Oxford have been asked to organise a one d training course for hospital staff at the Training School, Wormwood Scrubs. If successful, is hoped that the programme can be expanded.

Monitoring

8. Since March 1985 the DPMS has maintained a central record to enable it to monit the pattern of diagnosed cases, and potential cases, in the system. To date there has been o diagnosed case of AIDS among the inmate population. He died subsequently in a NH hospital. There is no known case in the system at present. On 23 April 1986 there were reported cases diagnosed as HTLV III antibody positive.

Isolation Facilities

9. The DPMS is anticipating the occurrence in small but steadily increasing numbers prison inmates who are not only HTLV III antibody positive, but who also have elements the AIDS syndrome. In these cases, the prison service can expect that it will be able transfer to NHS specialist units those cases which develop an "opportunistic" infection d to their lowering of bodily resistance, but who will in the less serious cases (ie non-termin recover temporarily sufficiently to be discharged from the unit. These cases will have return to the prison system, and there will be a need for facilities which can cope with the The problem associated with this development will be not only medical, but also industr in terms of both staff and inmate attitudes and reactions.

10. Initially, isolation facilities will be needed at a remand establishment since the fi main threat will be in the remand population. Plans have been submitted to the Treasury f their approval. The scheme involves extending the present hospital annexe at Brixton

accommodate four single cells with integral sanitation, an eight-bedded ward with adjoining showers and toilets, a treatment room, an office, a servery, clean linen and dirty linen stores, staff toilet and changing room etc. There are contingency plans for similar facilities in the North. It is intended that these facilities would not be solely for AIDS cases but for the management of infectious diseases generally.

Note 2

DRUG REHABILITATION CENTRES: HOME OFFICE FINANCIAL SUPPORT

The Home Office provides financial support to a number of voluntary organisations which run rehabilitation centres for drug misusers. This is done under the after-care grant scheme, which exists to aid the rehabilitation of offenders. Twenty-two drug rehabilitation projects are now funded under the scheme, all but one of which are residential establishments. Details of these projects are set out in the attached list.

HOME OFFICE AFTER-CARE SCHEME

DRUGS PROJECTS AS AT APRIL 1986

HOSTEL	PLACES/ OFFENDERS	MANAGEMENT	TYPE OF PROVISION	PROBATION AREA
Oldbury House Oldbury Court Road Fishponds, Bristol	12/8	Life for the World Trust	Christian residential rehabilitation Centre for males aged 18–30. Offenders with history of drug dependence or related offences.	Avon
Suffolk House Longbridge Slough Road Iver Heath	15/15	Turning point	Hierarchically structured residential community for physically withdrawn drug dependants of either sex	Buckinghamshire
Alpha House Wickham Road Droxford Southampton	37/16	Alpha House Ltd	Provision of rehabilitation programme for people with personality problems in particular those with drug related difficulties. Male and female 16–40 years.	Hampshire
St Vincents Salisbury Road Andover	9/8	The Coke Hole Trust	Accommodation and rehabilitative support from former male drug dependants aged 15–30.	Hampshire
Ashley Copse Smannell Road Andover	8/5	The Coke Hole Trust	Drug hostel. Girls and women up to 30 years.	Hampshire
Inward House 89 King Street Lancaster	12/9	Inward House Trust	Comprehensive programme for helping people who have problems with relationships including drug offences and personality disorders. Male and female, over 16.	Lancashire
Meta House 133 Princess Road Westbourne Bournemouth	8/6	The Bournemouth Project	Holding house for women with drug problems who are considering making applications to treatment centres.	Dorset

[Continued

Elizabeth House 14 Redcliffe Gardens SW10 10 Colville Terrace W11	24/13	Elizabeth House Association	Supportive community for men and women with drug related problems aged 20–30 who are motivated to remain drug free.	Inner London
Roma Turning Point 65/67 Talgarth Road W14	16/16	Turning Point	Accommodation and care for drug addicts referred from drug dependency units only.	Inner London
Featherstone Lodge 1 Eliot Bank, SE23	47/47	Phoenix House	Long Term therapeutic community for the rehabilitation of former drugs users.	Inner London
Battle Cottage Re-entry Unit 2 Sydenham Park Road SE26	13/13	Phoenix House	Former drug offenders of both sexes, 18–45.	Inner London
6 Waldram Park Rd London SE26	10/10	Phoenix House	Former drug offenders of both sexes, 18–45.	Inner London
Phoenix House Re-entry Project 20 Priory Road Sheffield	9/9	Phoenix House	Mixed sex, aged 20–40 who have completed the drug rehabilitation programme at Storth Oaks (which is not in Home Office scheme).	South Yorkshire
Esher Association:— Cranstoun 1 5 Ember Lane Esher	9/9	The Cranstoun Projects Ltd	Self-catering democratic community for recovering male drug addicts aged 18–28.	Surrey
Project 85 85 Trinity Road SW17	14/14	The Cranstoun Projects Ltd	Ex-drug addicts: second stage rehabilitation providing support towards return to independent living.	Inner London
City Roads (Crisis Intervention) Ltd 358 City Road London EC1			Short-term help to drug addicts.	Inner London
Parole Release Scheme Sisters Avenue SE11	12/12	The Cranstoun Projects Ltd	Supportive accommodation for drug dependent parolees.	Inner London

HOME OFFICE AFTER-CARE SCHEME—*(continued)*

DRUGS PROJECTS AS AT APRIL 1986

HOSTEL	PLACES/ OFFENDERS	MANAGEMENT	TYPE OF PROVISION	PROBATION AREA
Oak Lodge 136 West Hill SW15	14/14	The Cranstoun Projects Ltd	The long term aim is a resource for ex-offenders following their release from therapeutic and treatment oriented units in Prison Department establishments.	Inner London
235 Project 235 Balham High Road London SW12	13/13	The Cranstoun Projects Ltd	Supportive Accommodation for those with drug and alcohol related offences. No sex offenders, or people with a history of violence or current psychiatric illness.	Inner London
Richmond Fellowship HQ:—Addison Road London W14	400/45	Richmond Fellowship	Men and women who are difficult to place including drug addicts and alcoholics. The HO funded places are made available at various hostels in England and Wales. The main drugs hostel is as below:—	Inner London
Crescent House 10 St Stephen's Crescent W2		Richmond Fellowship	Therapeutic community for ex-drug abusers.	Inner London
Lifeline Project Day Centre and Regional Induction Unit 3 Joddnell Street Manchester		Lifeline Project Ltd	Day centre for addicts, and Regional Induction Unit, which has a two week programme for drug dependants to choose the appropriate option for their rehabilitation.	Greater Manchester

[Continued

Note 3

RESEARCH ON CHILD DEVELOPMENT IN PRISON MOTHER AND BABY UNITS

A research project, commissioned by the Home Office and undertaken by the University of Sussex, began on 1 March and will run for two years. Its formal brief is:—

"to study the physical and psychological development of babies during their residence in prison mother and baby units and for the three months following release, compared with the development of babies not subject to this experience".

There are three Prison Department mother and baby units—at Styal, Askham Grange, and Holloway (where the unit is due to move into new premises as part of the prison's redevelopment plans). The Sussex researchers are training staff to administer, and maintain records of, developmental tests on babies in the units as part of their normal daily duties. Follow-up testing on babies leaving the units and on the control group of babies (drawn from those whose mothers are eligible to apply for a place in a unit but who either choose not to apply or for whom a vacancy is not available) will be the responsibility of the project research workers who are hoping to combine this with routine Health Visitors' visits to the babies' homes.

[The Prison Department considers that this project will provide an independent evaluation of present mother and baby policy and practice and should also provide an operationally useful framework for regimes in the units which will help management and staff in their work.]

Note 4

PROTECTED ROOMS

Protected rooms are provided in prison hospitals as a facility the medical officer can consider using in instances where short-term placement in such accommodation might be beneficial to protect an inmate who, through some mental condition, presents as a danger to himself or others. Thus the occupants of protected rooms are generally in a disturbed condition and often capable of causing extensive damage to the fabric of the room. The ideal material would be both soft enough to protect the inmate against self-injury and yet resilient enough to withstand violent assault. Such conflicting requirements pose difficulties of design. There are other requirements too: the material should have insulation qualities and be capable of being coloured in a pleasing shade; it should not cause abrasions or be absorbent of body fluids.

The medical officers at Bedford and Birmingham prisons are not making use of their protected rooms because the fabric proved unresistant to the attentions of occupants. The Department is aware that the material currently used falls short of need and has been investigating alternatives. A new, specially manufactured material was experimentally installed at Ashwell Prison in March but has yet to be put to the test. [In May the same material is to be installed experimentally in Holloway.]

Note 5

PRISON MEDICAL OFFICERS: AGES

The following table shows the ages of the various grades of prison medical officers in five years age bands as at 20 April 1986.

Age Bands	*PMOs*	*SMOs*	*MOs*	*P/T MOs*
26–30				2
31–35		2	5	5
36–40		1	4	22
41–45			23	14
46–50	2	2	4	14
51–55	2	7	6	18
56–60	3	5	14	19
61–65	1	7	7	6
Over 65			3	3
Totals	8	24	66	103

Note: The figures for part-time medical officers include both half-posts (ie 10 hours or mo
per week but less than full-time) and quarter posts (ie less than 10 hours per week).

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APPENDIX 1

Supplementary memorandum by the Home Office

STATISTICAL NOTES ON THE PRISON MEDICAL SERVICE

(a) *Details of the prison population in each of the last ten years*

Average number of prisoners

Year	*Sentenced*	*Unsentenced*	*Non-criminal*
1975	33,733	5,609	478
1976	35,838	5,090	515
1977	35,659	5,281	630
1978	35,561	5,631	604
1979	35,591	6,132	497
1980	35,831	5,793	485
1981	36,022	6,905	384
1982	35,928	7,385	394
1983	35,487	7,651	324
1984	34,321	8,687	288

(b) *Establishment for and numbers of staff in post in each of the last ten years*

	Year	*Number in Post*	*Establishment*
(i) Full-time Medical Officers:	1976	88	
	1977	80	
	1978	78	N/A
	1979	81	
	1980	83	
	1981	83	
	1982	74	96
	1983	78	98
	1984	89	98
	1985	94	99
(ii) Part-time Medical Officers:	1976	44	
	1977	32	
	1978	32	
	1979	28	N/A
	1980	32	
	1981	35	
	1982	35	
	1983	40	
	1984	40	31
	1985	42	40
(iii) Nurses (all grades):	1976	111	
	1977	139	
	1978	142	N/A
	1979	139	
	1980	141	
	1981	132	
	1982	120	191
	1983	158	185½
	1984	145	193
	1985	145	193

	Year	*Number in Post*	*Establishment*
(iv) Hospital Officers (all grades):	1976	689	
	1977	688	
	1978	734	
	1979	749	
	1980	771	843
	1981	801	881
	1982	840	939
	1983	841	981
	1984	847	1017
	1985	884	1056
(v) Pharmacists (excluding technicians):	1976	14	
	1977	14	
	1978	13	
	1979	12	
	1980	13	
	1981	12	
	1982	14	14
	1983	14	14
	1984	14	$14\frac{1}{2}$
	1985	12	$14\frac{1}{2}$

Notes:

1. Central records of total Prison Medical Service staff complements are not readi available prior to 1982 (or 1980 for hospital officers). The establishment for these yea could not be ascertained in the time, or without significant cost.
2. The part-time medical officer posts are for the actual numbers of half-time posts (defin as part-timers working 10 hours or more per week but less than full-time). T establishment figures for 1982 and 1983 show only quarter-posts (ie less than 10 hou per week) and half-posts combined, and have therefore been omitted from the abo table.
3. The tables represent the numbers in post and the establishments for 1 December of t year in question, except that the establishment figure for hospital officers in 1980 is as 1 July.

(c) *Current numbers of full-time Medical Officers*

There are at present 98 full-time Medical Officers of whom 29 have psychiat qualifications and 25 have a "surgical" qualification. Of the latter group, six ha qualifications in obstetrics, five in gynaecology, three in pathology, two each in anaton neurology, public health and tropical medicine and one in anaesthetics. Some individu doctors have more than one such qualification.

(d) *Current numbers of part-time Medical Officers and appointments as visiting specialis*

Part-time Medical Officers:

Half-posts (ie 10 hours or more per week but less than full-time): 42
Quarter-posts (i.e. less than 10 hours per week): 65

The specialities of part-time Medical Officers are not recorded centrally but almost witho exception they are general practitioners.

Visiting Specialists:

127 psychiatrists (including 25 forensic psychiatrists)
40 venereologists
35 surgeons
20 radiologists
15 orthopaedic surgeons
9 dermatologists
4 anaesthetists

Among the paramedics are the following:

99 dentists
88 opticians
33 physiotherapists
9 chiropodists
6 speech or drama therapists

Note: Some individual specialists are approved for appointment to more than one establishment, and this may inflate the total number of specialists by about 10 per cent.

(e) *Current numbers of women Medical Officers*

There are currently 14 women Medical Officers of whom two are part-time and five are psychiatrists.

(f) *Current numbers of trained nurses*

There are 145 trained nurses in the Prison Medical Service of whom about 30 per cent have psychiatric qualifications. (Additionally, 131 hospital officers have nursing qualifications and about 50 per cent of these also have psychiatric qualifications.)

(g) *Total budget in each of the last ten years*

No separate budget is set for PMS. Across the Prison Service as a whole, medical services are estimated to have cost £31.8 million in the 1984–85 financial year. (This estimate was made on the basis of information from the Prison Costing System, an integrated Parliamentary Vote and "activity" costing system introduced in April 1983). Reliable estimates on a comparable basis are not available for previous years.

(h) *A breakdown of the current budget*

The costs of PMS staff can be separately identified only where there are fixed complements for the staff concerned. The costs for staff in 1985–86 shown below are in terms of forecast expenditure on the Prisons Vote (Class IX, Vote 8) and thus exclude superannuation costs:

1985–86	*£000*
(i) Doctors—employed by the Department full-time: No complement levels are fixed for locums and visiting specialists whose costs cannot be separately identified.	2,333
Doctors—employed by the Department part-time:	639
(ii) Nursing staff—nurses:	1,597
Nursing staff—hospital officers:	13,883
(iii) Pharmacists	230
(iv) Prison hospitals—costs are not separately identifiable either from the Prison Costing System or in terms of direct expenditure on the Prisons Vote.	—
(v)* Drugs—these costs, although not separately identifiable either from the Prison Costing System or in terms of direct expenditure on the Prisons Vote, are an element within a subsubitem of the Prisons Vote (A3(2)(6)(1)) dealing with supplies for Prison Medical and Pharmaceutical Services: see (vi) below.	—

(vi)* Forecast Voted expenditure on:		
Supplies for Prison Medical and Pharmaceutical Services	1256	
Dental charges for inmates	708	
Optical charges for inmates	92	
Equipment, including surgical instruments and servicing	228	2,28
Travelling expenses—outside medical staff:		23

* (The voted expenditure on (v) and (vi) for the previous four years was as follows:

	£000
1981–82	1,482
1982–83	1,717
1983–84	2,025
1984–85	2,198.)

(i) *Current pay and superannuation arrangements for Prison Medical Officers*

Details of the current pay and superannuation arrangements for Prison Medical Office and for NHS doctors and psychiatrists are in Appendix 2.

(j) *Current pay and superannuation arrangements for nurses, hospital officers and prisc officers*

1. Prison Officer Class

(i) Rates of pay, with effect from 1 April 1985

Chief Officer I: single salary point (annual): £11,173
Chief Officer II: salary scale (annual): £9,923; £10,345
Principal Officer: salary scale (weekly): £151.73; £155.65; £163.21
Senior Officer: salary scale (weekly): £135.69; £139.15; £145.71
Prison Officer: salary scale (weekly): £103.21; £107.67; £111.52; £115.52; £119.6 £126.62; £130.96 after 12 years effective service; £135.34 after 15 years effecti service
Prison Auxiliary/Temporary Officer: salary scale (weekly): £101.39; £103.9 £105.65; £107.55; £109.16; £113.48
Night Patrol: salary scale (weekly): £107.98; £110.46; £112.17; £114.08; £116.0 £120.53
House Matron: salary scale (weekly): £146.66; £151.73; £155.65; £163.21

All these grades attract London Weighting which is at present £1,365 per annu for the Inner London Zone (£1,015 if officer living in official quarters), £765 for tl Intermediate Zone (£560 if in official quarters) and £545 for the Outer Zone (£399 in official quarters). In addition to the basic rates of pay, night and shift disturban allowance and overtime and premium pay are also payable, as shown in tl following two sections and as at the points corresponding to those on the basic sala scales. There are also further allowances (not shown in this paper) payable to Prisc Officers who undertake specialist duties.

(ii) Night and Shift Disturbance Allowance, with effect from 1 April 1985

Principal Officer: weekly rate: £19.12; £19.61; £20.56
hourly rate (pence): 47.8; 49.0; 51.4
Senior Officer: weekly rate: £17.10; £17.53; £18.36
hourly rate (pence): 42.8; 43.8; 45.9
Prison Officer: weekly rate: £13.00; £13.57; £14.05; £14.56; £15.08; £15.95; £16.5 £17.05
hourly rate (pence): 32.5; 33.9; 35.1; 36.4; 37.7; 39.9; 41.3; 42.6
Prison Auxiliary: weekly rate: £12.78; £13.10; £13.31; £13.55; £13.75; £14.30
hourly rate (pence): 32.0; 32.8; 33.3; 33.9; 34.4; 35.8

(iii) Hourly Rates of Overtime and Premium Pay (in pence) (identical except in the o instance where shown separately).

Principal Officer: 415.6; 425.4; 440.1 (overtime), 444.3 (premium)
Senior Officer: 375.5; 384.2; 400.6
Prison Officer: 294.3; 305.5; 315.1; 325.1; 335.4; 352.9; 363.7; 374.7

Prison Auxiliary: 253.5; 259.9; 264.1; 268.9; 272.9; 283.7
Night Patrol: 240.0; 245.5; 249.3; 253.5; 258.0; 267.8

(iv) Superannuation

Prison Officers, as civil servants, are superannuable under the Principal Civil Service Pension Scheme. For prison officers, including Hospital Officers, the minimum retiring age is 55 rather than 60, and after 20 years of actual service further service reckons for superannuation purposes at double its length.

2. Prison Hospital Staff

Prison Hospital staff receive the basic Prison Officer class salary scale appropriate for their grade (see 1(i) above). They are also eligible for the same additional payments, allowances and superannuation benefits as the Prison Officer Class. Further allowances are also payable as follows:

Chief Officer: £418.00 per annum
Principal Officer: £8.03 per week
Senior Officer: £8.03 per week
Prison Officer: £8.03 per week
EEG allowance: £7.78 per week
Part-time EEG allowance (half week or more): £3.91 per week
EEG allowance (per recording): £0.34
Audiometric recording (per recording): £0.22

3. Nursing Staff in the Prison Medical Service

(i) Rates of pay

Senior Principal Sister: salary scale from 1 April 1985: £8,714; £9,042; £9,372; £9,664; £9,993; £10,319
salary scale from 1 February 1986: £9,502; £9,830; £10,160; £10,452; £10,781; £11,107

Principal Sister: salary scale from 1 April 1985: £8,482; £8,805; £9,124; £9,446; £9,766; £10,089
salary scale from 1 February 1986: £9,270; £9,593; £9,912; £10,234; £10,554; £10,877

Senior Sister: salary scale from 1 April 1985: £8,031; £8,367; £8,707; £9,047; £9,387; £9,725; £10,065
salary scale from 1 February 1986: £8,333; £8,753; £9,173; £9,593; £10,013; £10,433; £10,853

Sister: salary scale from 1 April 1985: £7,220; £7,556; £7,896; £8,236; £8,576; £8,914; £9,254
salary scale from 1 February 1986: £7,480; £7,900; £8,320; £8,740; £9,160; £9,580; £10,000

Senior Enrolled Nurse: salary scale from 1 April 1985: £5,708; £5,958; £6,209; £6,459; £6,710; £6,960
salary scale from 1 February 1986: £6,000; £6,235; £6,470; £6,705; £6,940; £7,175

Enrolled Nurse: salary scale from 1 April 1985: £5,141; £5,317; £5,494; £5,670; £5,848; £6,025; £6,201
salary scale from 1 February 1986: £5,270; £5,475; £5,680; £5,885; £6,090; £6,295; £6,500

Nursing Auxiliary: salary scale from 1 April 1985: £3,950; £4,142; £4,321; £4,497; £4,674; £4,850; £5,069
salary scale from 1 February 1986: £3,950; £4,145; £4,340; £4,535; £4,730; £4,925; £5,120

In addition all these posts attract London Weighting which is at present £839 per annum (non-resident staff) and £233 per annum (resident staff) in the London Zone, and £149 (non-resident) and £38 (resident) in the Fringe Zone. All Prison Nursing Staff receive the Environment allowance at the rate of £779 a year.

(ii) Charges for lodging

Yearly lodging charges for resident nursing staff with effect from 1 April 1985 are a the following rates:

Senior Principal Sister:	£675
Principal Sister:	£675
Senior Sister:	£675
Sister:	£675
Senior Enrolled Nurse:	£486
Enrolled Nurse:	£486
Nursing Auxiliary:	£463, but £357 if accommodation shared

(iii) Special duty and night duty payments for Nursing Auxiliaries (hourly rate)

These are paid at the points corresponding to those on the basic salary scale (see 3(above).

Sundays and Public Holidays: scale from 1 April 1985: £1.6168; £1.6824; £1.743 £1.8038; £1.8642; £1.9244; £1.9994

scale from 1 February 1986: £1.6168; £1.6834; £1.7500; £1.8168; £1.883 £1.9500; £2.0168

Saturdays and Weekday Nights: scale from 1 April 1985: £0.8084; £0.8412; £0.871 £0.9019; £0.9321; £0.9622; £0.9997

scale from 1 February 1986: £0.8084; £0.8417; £0.8750; £0.9084; £0.941 £0.9750; £1.0084

(iv) Superannuation

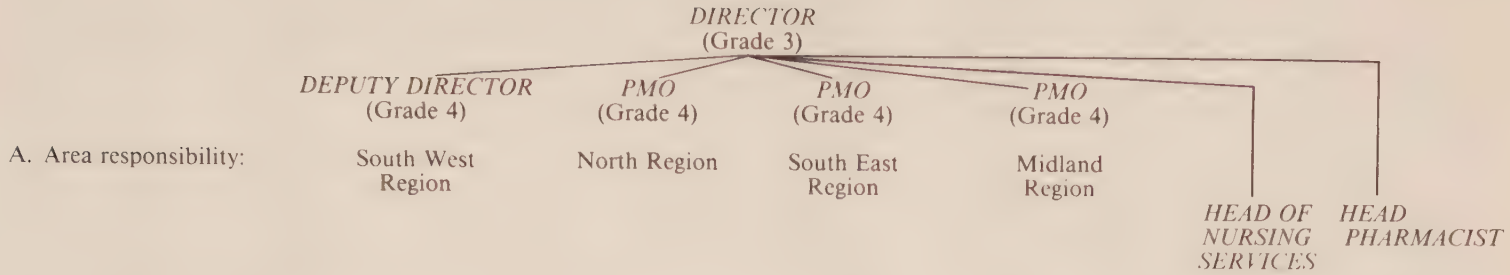
Prison Nursing Staff are superannuable under the National Health Servi Superannuation Scheme.

(k) *Details of management development courses*

An induction course is held each year for newly entrant Prison Medical Officers. Th covers a range of management advice and instruction as well as exclusively medical topic Among the former are "The Role and Responsibilities of the Prison Doctors"; "Governor Expectations of a Medical Officer", and "The Financing of the Prison Medical Service This course is followed by a development course for Prison Medical Officers who have be in post for about two years. Doctors who aspire to promotion to Senior Medical Officer a encouraged to attend the "Introduction to Management for Senior Staff" course held at t Civil Service college.

Organisation of the Directorate of Prison Medical Services

A diagram is attached.



A. Area responsibility:	South West Region	North Region	South East Region	Midland Region	
B. Functional/advisory responsibility includes:	Medical policy female establishments; Accommodation for medical use; AIDS.	Hygiene; Nutrition; Health and Safety; Occupational Health	Dental and Optical; Surgical services; Training of medical staff (and medical liaison on training hospital staff).	Mentally disordered offenders; Young offenders; Research projects Medical documentation.	

NOTES

1. Item A includes managerial visits (totalled 163 between 1.10.84 and 30.9.85).
2. Item B functions included are not exhaustive and are shown for illustrative purposes.
3. The Head of Nursing Services is directly accountable to the Director for the operation and related policy of hospital officer and nursing services throughout the prison system. He works with individual PMOs on matters such as staffing provision in respect of prison establishments for which they have area responsibility.

APPENDIX 2

Supplementary memorandum by the Home Office

RATES OF PAY AND CONDITIONS OF SERVICE FOR DOCTORS

A. Prison Service Medical Staff

(i) *Rates of Pay*

Principal Medical Officer:	Salary scale from 1 July 1985: £27,306 £27,635 £27,965 Salary scale from 1 March 1986: £27,335 £27,994 £28,653
Senior Medical Officer:	Salary from 1 April 1985: £25,533
Medical Officer:	Salary scale from 1 April 1985: £16,597 £17,376 £18,302 £19,353 £20,679 £22,344 £23,515

In addition all these grades attract London Weighting which is at present £1,365 p annum for the Inner Zone, £765 for the Intermediate Zone and £545 for the Outer Zon There are various other allowances payable.

(ii) *Normal Retirement Age*

The minimum retirement age for Principal Medical Officers, Senior Medical Officers ar Medical Officers is 60. Because of difficulties experienced in the past in filling these pos prison medical staff have usually been allowed to continue in service until age 70, b anyone staying on in this way must revert to the basic Medical Officer grade at age 65. The are no special superannuation arrangements.

(iii) *Conditioned Hours of Work*

The conditioned hours are 41 per week in London and 42 elsewhere.

B. National Health Service Doctors

Hospital Doctors

(i) *Rates of Pay, all with effect from 1 June 1985*

Consultant:	Salary scale: £21,460 £23,020 £24,580 £26,140 £27,700
Senior Hospital, Medical or Dental Officer:	Single point salary: £21,460
Associate Specialist:	Salary scale: £13,160 £14,580 £16,000 £17,420 £18,840 £20,260 £21,680
Child Psychiatrist:	Single point salary: £21,920
Senior Registrar:	Salary scale: £,12,380 £13,030 £13,680 £14,330 £14,980 £15,630
Registrar:	Salary scale: £10,760 £11,300 £11,840 £12,380 £13,030
Senior House Officer:	Salary scale: £9,480 £10,120 £10,760

House Officer: Salary scale:
£7,610 £8,100 £8,590

House Officer with provisional Registration: Salary scale:
£7,610 £8,100

In addition all these posts attract London Weighting which is at present £839 per annum (non-resident staff) and £233 (resident staff) in the London Zone, £149 (non-resident) and £38 (resident) in the Fringe Zone and £527 (non-resident) and £147 (resident) in ETM and Contigious Units. There are various other fees, charges and allowances payable.

(ii) *Distinction Awards: Consultants*

In addition to their basic salary consultants are eligible for distinction awards at the following levels and to the extent shown:

A plus award	=	£24,930 (162)
A award	=	£19,200 (602)
B award	=	£10,970 (1,649)
C award	=	£4,890 (3,792)

Once made these awards remain payable as part of the consultants' total remuneration until retirement and are reckonable for superannuation purposes. I understand that at any one time about 36 per cent of consultants are in receipt of a distinction award, and that some two thirds of consultants are in receipt of an award when they come to retire.

(iii) *Normal Retirement Age*

The normal retiring age is 65 but in practice most doctors retire slightly earlier. Doctors who are permanently appointed to Psychiatric Units or Psychiatric Hospitals, and who thereby obtain mental health officer status, can, provided they have completed 20 years of contributing reckonable Mental Health Act service, begin to double their completed years of service for superannuation purposes. In this way, it is possible for Mental Health Officers to retire on a full pension at age 55. For other grades there are no special superannuation arrangements.

(iv) *Conditioned Hours of Work*

For Consultants there are no formal hours of work. The contract implies a minimum commitment of 11 sessions per week of $3\frac{1}{2}$ hours, although equally there is a contractural commitment to have a 24 hour responsibility for the patient. For junior doctors there is a standard 40 hour week. In practice they work longer hours and special rates are payable for being on call or working outside of the standard week (30–38 per cent of basic rate).

Doctors in Special Hospitals

(i) *Rates of Pay*

As for Hospital Doctors, but also £1,265 per annum special hospitals lead. Consultant Psychiatrists having the status of Responsible Medical Officer, receive in addition 10 per cent of the current maximum of the Medical Consultants' scale. The Medical Directors in each of the special hospitals receive in addition a special allowance normally 46 per cent of the maximum of the Consultants' scale.

(ii) *Normal Retirement Age*

As for Hospital Doctors including the superannuation provisions.

(iii) *Conditioned Hours of Work*

As for Hospital Doctors.

General Practitioners

(i) *Rates of Pay*

The Government approved the recommendation in the Fifteenth Report of the Revie Body on Doctors' and Dentists' Remuneration that the average net remuneration, befo tax, for general Medical Practitioners should be £23,440, and the average gro remuneration including practice expenses should be £34,950 with effect from 1 June 198

The method of remunerating doctors providing general medical services under th National Health Service resulted from negotiations between the Minister of Health ar General Practitioner representatives, following publication of the profession's "Charter f the Family Doctor Service", early in 1965. The principal payments (which may inclu expenses elements) under the scheme of remuneration are:

1. A basic practice allowance to recognise commitments and obligations which do n vary proportionately to the size of the list.
2. Special allowances to recognise seniority, practice in groups, practice in designate areas and vocational training.
3. A capitation fee for each patient on a doctor's list.
4. Payments for out-of-hours responsibilities including a supplementary practice allo ance, supplementary capitation fees and night visit fees.
5. Payments for:
   (a) Vaccinations, immunisations and cervical cytology tests carried out for reasons public policy.
   (b) The treatment of temporary residents.
   (c) The provision of maternity medical services and contraceptive services.
6. Payments in respect of: employment of ancillary help; rent and rates of premis (including notional rent for owner-occupied premises and cost rent for new purpo built premises); employment of locums during the doctor's own sickness confinement.
7. Payments under the Doctors' Retainer Scheme.

The levels at which the main fees and allowances should be paid are based c recommendations made by the Review Body on Doctors' and Dentists' Remuneration s up in accordance with the recommendations of the Royal Commission on Doctors' ar Dentists' Remuneration "to advise the Prime Minister on the remuneration of doctors ar dentists taking part in the National Health Service".

(ii) *Normal Retirement Age*

There is no set retirement age and there are no special superannuation arrangements.

(iii) *Conditioned Hours of Work*

There are no set hours.

APPENDIX 3

Supplementary memorandum by the Home Office

PRISON SERVICE MEDICAL OFFICER GRADES: PROPOSED "ON CALL" ALLOWANCE

1. A significant rubbing point for prison medical officer grades is the condition of servi that imposes on them (unlike their counterparts in most of the administrative remainder the medical civil service) a liability to be "on call" to attend in emergency in the evenin during the night, and at weekends, as well as undertaking routine medical duties Saturdays and Sundays. It has, of course, to be made clear when an appointment is offer that a 5-day week is not normally practicable, and that prison medical officer grades mu expect to have a regular liability to be on-call on certain weekends and nights.

2. Prison medical officers at the moment receive no financial recognition or compensation for these extra duties. This is a source of discontent which affects the morale of the service as a whole. Furthermore, under the present arrangements it is difficult to impose a requirement that all prison medical officers meet their expected on-call availability and weekend duty, so that in practice the average number of nights spent on-call and on weekend duty falls somewhat below this expectation. In consequence, because of the statutory requirements for 24 hour medical cover, locum tenens have to be employed to cover those periods when a prison medical officer grade is not on call or on duty. It is understood that this situation is one that affects prison medical officer grades uniquely within the general Civil Service class.

3. Leaving aside considerations of equity (which nevertheless ought not to be lightly disregarded), the managerial benefits of the payment of some form of an allowance to compensate for this substantial "out of hours" commitment would:—

(i) go some way to underpin the recently improved recruitment position;
(ii) lead to a reduction in the requirement to employ locum tenens which will effectively off-set at least in part the cost of any proposed allowance;
(iii) enable the Medical Directorate to tighten the requirements by insisting on a minimum number of evenings/nights each year during which there is a liability to be on-call, and a minimum number of weekends to be worked;
(iv) improve the morale generally of the Prison Medical Service.

The decision to pursue the case for an allowance has been discussed by the Inter-Departmental Management Committee of the Medical Civil Service, who accepted the validity of the special case that had been made.

4. The arithmetical basis on which an allowance might be calculated is shown in the assessment attached.

PRISON SERVICE MEDICAL OFFICER GRADES: PROPOSED "ON CALL" ALLOWANCES

1. The allowance might usefully be assessed on the basis of the fees payable to medical practitioners engaged to act as locum tenens for full-time medical officers. The current fee for "on-call" availability for 16 hours is £26, and that for attendance for a session is £43.

2. Allowing for 6 weeks annual leave, and to ensure that medical officers will be "on-call" for:—

Not less than one evening and one night each week, and to undertake duty attendance on Saturday and Sunday morning on one weekend in every four

an allowance might be calculated as follows:—

46×£26 =£1196
12×2×£43 =£1043

£2228p.a.

3. The demand on senior prison medical officers is rarely a regular one, and certainly lower than that for medical officers. Generally, they provide cover when the basic grade medical officers and locums on the duty roster are on leave or otherwise not available. However, Prison Department also propose to require senior medical officers to undertake some minimum commitment for on-call liability and weekend duty, and propose an allowance at *half* the rate for prison medical officers ie. £1,114 per annum.

4. On the basis of these proposals, the total cost of allowances would be:—

Medical Officers 51×£2,228 =£113,628
Senior Medical Officer 25×£1,114 =£ 27,850

£141,478p.a.

5. The savings in fees for locum tenens are estimated to be about £75,000 per annum. This estimate has been arrived at following an assessment of information returns for one month from all establishments with a full-time Medical Officer of the amount of on-call/weekend duty undertaken and the amount paid in fees to locums.

APPENDIX 4

Supplementary memorandum by the Home Office

GUIDELINES FOR THE MANAGEMENT OF HEPATITIS B

1. Hepatitis B carriers probably represent some 7 per cent of the total population of t British Isles. Most are unaware of their carrier state. There is a high incidence in dr addicts, prostitutes (both male and female), homosexuals and tattooed people.

Acute Illness

2. The following procedure is recommended for patients in the acute phase:—

(a) isolation in a single room in the hospital with his own utensils until his blo biochemistry has returned to normal;
(b) a fat free diet;
(c) concentrated vitamin supplements;
(d) high fluid intake; and
(e) strict control over disposal of all body waste.

Carrier State

3. The carrier state can last for many years but usually ceases between three months a two years after the acute illness, and is monitored by blood tests every three month Inmates giving a history of Hepatitis should be treated as carriers until a negative blood t is received. The disease is communicable in this state only by direct contact of body fluids the carrier with those of the recipient i.e. by kissing, all form of sexual activity (hetero homo) and contamination of open wounds by carrier body fluids.

4. Hepatitis B carriers may be placed on ordinary location under the followi conditions, known as Hepatitis restrictions.

(a) Location—in a single cell or communal cell with other Hepatitis carriers.
(b) They must be provided with their own utensils including a locked razor and str control must be maintained over disposal of all body waste.
(c) Labour 2—no machinery, no sharp instruments, knives, needles, etc., and n connected with food preparation or distribution in any way.
(d) A strict understanding of, and adherence to, the rules of persons hygiene wi particular emphasis on procedure in the event of accidents involving spillage of bo fluids, blood, urine, saliva, faeces, etc. In such circumstances:
  (i) the hospital to be informed immediately;
  (ii) all cleaning up to be done under the supervision of a Hospital Officer; and
  (iii) disposal of all dressings by the hospital.
(e) No PE or games.
(f) An understanding by the prisoner of the possible modes of communication of t disease and an undertaking to take every precaution to prevent any su communication.

5. A Hepatitis restriction sheet should be sent to the Governor, Centre Control, Wing G and Landing staff, and Staff Information Room; all of whom should also be inform when the restrictions are lifted.

6. In the event of accidental inoculation, or when a member of staff gets blood fro Hepatitis B carrier into a cut or abrasion or into the eye or mouth, the affected area shou be washed well immediately. The member of staff responsible for reporting accidents shou be notified promptly and should telephone the nearest Public Health Laboratory Hepatitis Reference Laboratory for advice. Health Authorities should have a clear writt policy for reporting of all accidents. Supplies of Hepatitis B immuno globulin are held the Public Health Laboratory Service and should be given as soon as possible after t incident and preferably no later than 48 hours.

7. In the case of accidental inoculation with blood from a patient of unknown Hepatitis status, the patient should be tested for Hepatitis B Antigen as soon as possible to assess t possible significance of the incident. This is particularly important when the patient fa into a high risk category.

APPENDIX 5

Memorandum submitted by the Scottish Home and Health Department

PROVISION OF HEALTH SERVICES TO PENAL ESTABLISHMENTS IN SCOTLAND

INTRODUCTION

1. The provision of health services to penal establishments in Scotland has developed on the basis of agreements between the Scottish Prison Service and general practitioners or health boards to supply an agreed level of service to particular institutions. At present the 23 prison establishments in Scotland contain about 5500 inmates. The level of general practitioner, dental, psychiatric or psychological service to any particular institution is a matter for discussion between the Scottish Prison Service and a local medical or dental practitioner or health board as the case may be. The service provided is essentially part-time and much of the day to day health care of inmates devolves to Nursing Officers working full-time in penal establishments.

PRISON SERVICE MEDICAL ADVISER

2. The Scottish Prison Service is advised on all medical issues by the Prison Service Medical Adviser (PSMA) based in Prisons Group HQ but accountable to the Chief Medical Officer of the Scottish Home and Health Department (SHHD). The PSMA is responsible for advising on the provision of satisfactory medical, psychiatric and nursing services to establishments and for the integration of prison service medical services with the other disciplines involved in running prisons.

HOSPITAL FACILITIES

3. All establishments have hospital facilities adequate to treat inmates who do not require 24 hour nursing care. Only at Barlinnie Prison—by far the largest institution currently holding about 1400 inmates—is the hospital equipped to provide full-time cover. It is therefore employed as a regional hospital, taking from other establishments patients who do not require the full sophistication of NHS treatment yet who may not be properly cared for in their own establishment.

MEDICAL OFFICERS

4. With the exception of Barlinnie, primary care is provided entirely by general practitioners employed on a part-time basis. Continuity of care is ensured by appointing doctors who are members of group practices with partners prepared to contribute out-of-hours, sickness and holiday cover. In some establishments routine work is shared between 2 or more partners. At Barlinnie, medical care is provided by 3 full-time doctors (one Senior Medical Officer and 2 Medical Officers) assisted by 4 part-time Medical Officers.

5. In the Scottish Prison Service as a whole 21 part-time Medical Officers appointed by the Secretary of State are employed for approximately 178 hours a week. Under the Prison (Scotland) Rules, 1952, each has responsibility for the general care of the health of inmates and for attending all sick inmates in the establishment to which each is appointed. The Medical Officer, or in certain circumstances, a nurse officer under his direction is required:

(a) to examine all inmates on reception, transfer and discharge and all inmates who complain of illness;

(b) to see daily every inmate under restraint, confined to a room or in cellular confinement;

(c) to treat or to arrange for treatment to be given either within the establishment or at a hospital to any inmate whose physical or mental condition so requires;

(d) to inform the Governor when he believes an inmate's health is likely to be injuriously affected by continued imprisonment or a particular regime or when he suspects that an inmate may be dangerously ill or might have suicidal tendencies;

(e) to oversee, and advise the Governor on, matters affecting the health and hygiene of the inmates and the establishment including cleanliness, diet, sanitation, heating, lighting and ventilation;

(f) where necessary for the prevention of spread of communicable diseases to liaise w the Community Medicine Specialist of the health board for the area.

In addition to these duties the 3 full-time Medical Officers, although not psychiatris examine and report for the Courts on inmates on remand. They also undertake p employment medical examination of recruits to the Scottish Prison Service.

Nurse Officers

6. The part-time nature of the medical service to institutions necessitates the appoi ment at every establishment of trained nurses. The nurses are selected from among pris officers following a period of assessment at one of the larger prison hospitals. Candidates interviewed by the PSMA and, if accepted for nursing duties, they are detached undertake training to Enrolled Nurse standard at one of 3 Schools of Nursing. This ini training takes 2 years and refresher training is arranged locally in co-operation with Ch Administrative Nursing Officers of health boards. Consideration is being given to possibility of arranging secondment of some nursing staff to admission wards of psychiat units to gain experience in the management of persons who are psychotic, aggressi suicidal or manipulative.

7. There are 91 Nurse Officers (7 of whom are women) currently employed in the Scott Prison Service. They are in 4 grades of seniority (one Chief, 10 Principal, 14 Senior and basic grade). All are employed within the management structure of their individ establishments—there is no Head of Nursing Services. When information or advice required this is provided by the PSMA in consultation, as necessary, with the staff of Nursing Division of SHHD.

8. Nurse Officers are required to assist the Medical Officers to discharge their statut responsibilies for the care and welfare of prisoners. They are also responsible under Governor for the control and security of drugs and for ensuring in regular consultation w the pharmacist of the NHS hospital which supplies them, that the measures taken are accord with good modern practice.

Psychiatrists

9. Consultant psychiatric support to establishments is provided on a part-time ba Psychiatrists are employed by health boards and their services are purchased by the Scot Prison Service on a sessional basis. Thus, while they work in penal establishments, t continue to work in the community in general and assist in maintaining links between medical services in penal establishments and the NHS.

10. There are currently 14 psychiatrists employed in the Prison Service in Scotl providing a total of 48 sessions (a session is a half-day) each week. Some are forer psychiatrists and some general, with an interest in forensic psychiatry. In addition providing continuing care for individual offenders they give specialist advice to Med Officers and Governors on the management of disturbed inmates who can be treated wit the establishments. They also provide reports for the Parole Board for Scotland but they not required, in the course of their prison duties, to make examinations and furnish rep for the Courts. As a rule, such reports are made by general and other psychiatr nominated and remunerated by the prosecution service.

Psychologists

11. The appointment arrangements for psychologists to service the needs of establ ments in Scotland are broadly similar to those for psychiatrists. Of the 10 who provi total of 44 sessions per week to Scottish establishments 9 have appointments with he boards and one is on the staff of the State Hospital at Carstairs. Their role is less well defi than that of their colleagues in the NHS medical disciplines and will vary fr establishment to establishment. However, their contribution towards the manage within institutions of more difficult prisoners, especially those serving longer sentence valued by staff. On the basis of their assessment of difficult inmates psychologists advis the treatment of individuals or groups within an establishment. From time to time they also advise on aspects of staff training and the development and evaluation of proced

and regimes. The Prison Service reimburses the State Hospital for part of its costs in training clinical psychologists.

Dentists

12. Primary dental care is available to all inmates and provided by appointed visiting dentists operating under NHS terms and conditions of service and receiving payment for items of dental work completed. In addition each dentist receives a small statutory fee, agreed at UK level, for each visit and payment of travelling expenses. When appointed, the dentist undertakes to give a regular time commitment to ensure there is no undue delay in routine treatment being received. In addition, the dentist will respond to emergency calls.

13. The Scottish Prison Service is responsible for payment to the dentist of the statutory NHS patient fee and the nature of treatment given is monitored by the Scottish Dental Estimates Board. The quality of treatment is a matter for the Regional Dental Officer. The Deputy Chief Dental Officer of SHHD also acts as Senior Dental Adviser to the Scottish Prison Service and as manager of the prison dental service. There are currently 14 dentists providing services to establishments in Scotland. In each establishment facilities, including specialist equipment for the dentist, are provided on an appropriate scale.

General

14. The provision of medical services in Scottish penal establishments has evolved not on a central or national model but on the basis of relationships between individual establishments and local general practitioners or health boards. These arrangements ensure (by and large) that those providing services within institutions retain their day-to-day links with practice in the wider community and enjoy ease of access to NHS facilities for the investigation and treatment of inmates. Similarly, at the centre, the PSMA has the ability to seek, where necessary, the guidance of specialist staff in SHHD whose interest extends to the provision of medical, psychiatric nursing or dental services for the community as a whole.

15. To bring together the various components the PSMA makes frequent visits to establishments, gives medical advice on policy issues and on the selection and appointment of medical and nursing staff and maintains contact with the NHS thus enabling him to provide the liaison necessary to support the continuation of a satisfactory service.

APPENDIX 6

Supplementary memorandum by the Scottish Home and Health Department

TRAINING OF NURSE OFFICERS IN THE SCOTTISH PRISON SERVICE

. Introduction

Since 1971 all new entrants to the nursing grades have attended a 72 week course at one of three Scottish Schools of Nursing and Midwifery and are therefore trained to Enrolled Nurse standard before taking up nursing duties at an establishment. After a minimum of five years' experience in the prison nursing grades, and at regular intervals of five years provided that the staff can be released, nurse officers receive refresher training in the form of attachments to accident and emergency units and to psychiatric wards in local NHS hospitals. In addition, nursing staff may request attendance on external courses or conferences (eg on specialist subjects such as drug problems, Hepatitis 'B' and AIDS) and these requests are considered by the Prison Service Medical Adviser (PSMA).

. Selection for Training

The initial training of nurse officers is a demand led process and therefore applications are sought from discipline staff when it is anticipated that, due to retirals, promotions and changes in nursing complements, a shortage of nursing staff may arise. This requires the demand situation to be anticipated two years in advance because the nursing course extends over a period of 72 weeks and is followed by a three month assimilation period before newly-trained nursing staff are posted.

A letter is sent to all establishments inviting applications and these are considered, wi the Governor's accompanying comments, in an initial sift undertaken by Personn Management branch. Officers who are over 45 years of age, who have not completed the probationary period, who do not have satisfactory Annual Reports or who are not deem to have demonstrated the necessary commitment to enter the nursing grades are rejected this stage. The remaining applicants are given the opportunity to serve in a local pris hospital for a period of fourteen days to enable them to be assessed and to learn more abo the nature of the work. On completion of this two week period, the PSMA interviews each the candidates and considers the assessment reports provided by the Chief/Principal Nur Officer at the prison hospital to which the candidate was detached. He is then in a positi to make a recommendation on the suitability of each candidate to undertake nursi training, and to place the candidates in order of preference.

The requisite number of officers from those recommended by the PSMA are then asked apply to one of the following three schools of nursing:
North Lothian College of Nursing and Midwifery
Glasgow Eastern College of Nursing and Midwifery
Foresterhill College (Aberdeen)
the choice between these being dependent on the officer's home location and on his perso preference. It is necessary for the officers to be attached to either Barlinnie Prison (f Glasgow Eastern College), Edinburgh Prison (for North Lothian College) or Aberde Prison (for Foresterhill College) for the duration of their training and subseque assimilation period, although a costly transfer is avoided where possible.

The colleges require minimum entrance qualifications as follows:
North Lothian College—2 SCE 'O' Grades (one of which must be English)
Foresterhill College—2 SCE 'O' Grades (one of which must be English)
Glasgow Eastern College—4 SCE 'O' Grades (including English and Arithmetic)
and any officer who does not possess these is required to sit an entrance test. In addition, applicants are required to attend an informal interview. Applicants from the prison serv have not, in the past, been rejected at this final stage of the selection process. Bef commencing training, the officers are required to sign an undertanding to serve at least th years in a nursing capacity in the Scottish Prison Service on completion of the course.

A summary of the result of the four most recent trawls is given below:

Date of letter seeking applications	*Number of applicants*	*Number commencing training*
1 August 1978	19	10
7 August 1980	24	7
29 April 1983	19	7
11 September 1985	18	7

3. Training Period

The Enrolled Nurse course extends over a period of 72 weeks (exclusive of four we annual leave and 10 days public holidays) and covers the following subject areas:—
(1) Care of the Elderly
(2) Care of the Mentally Ill
(3) Care of the Physically Ill receiving medical treatment
(4) Care of the Physically Ill receiving surgical treatment

Theoretical instruction on each of these modular components is given in study block the college, and is followed by a period of practical experience in the ward of a lo hospital. Pupils are deemed to have successfully completed a module when they h obtained a satisfactory progress report from the Registered Nurse in charge of the w where the practical experience was undertaken, have passed the written examination that module and have maintained satisfactory standards of nursing care and of behavi and satisfactory levels of attendance. One opportunity to repeat the module is given satisfactory standard is not achieved.

Towards the end of the training period, pupils sit the National Board for Nurs Midwifery and Health Visiting for Scotland examination for a second level course. A pas this examination enables the officers to apply to the UK Central Council for registration

second level nurse. All Scottish Prison Service staff commencing the Enrolled Nurse course within the last ten years have successfully completed it.

After completion of the course each officer undergoes a three month assimilation period in prison nursing procedures at the appropriate establishment. At this stage the officers begin to receive the nursing allowance of £8.41 + 12.6 per cent Shift Disturbance Allowance (SDA) totalling £9.47. During training they receive the appropriate prison officer rate + 12.6 per cent SDA.

4. Refresher Training

Following a survey of refresher training for nurse officers carried out by SHHD nursing staff in 1980, CANOs in whose areas we have a penal establishment were approached in 1982 requesting facilities for periodical refresher training. Short attachments (usually of two weeks duration) to accident and emergency units and to psychiatric wards of NHS hospitals are arranged locally between the prison nursing staff and the appropriate Health Board. This has superseded the practice of detaching nursing staff to the State Hospital at Carstairs for short periods, although this facility is still available and the practice could be revived. The following table indicates the refresher training which has taken place since 1983:

Establishment	*Year*	*Number of Staff involved*	*Location and Duration of training*
Aberdeen	1984	2	1 week at Foresterhill General
			1 week at Cornhill Psychiatric
Dumfries	1985	1	1 week at Dumfries General
			1 week at Crighton Psychiatric
Dungavel	1985	1	1 week at Foresterhill General
			2 weeks at Cornhill Psychiatric
Glenochil	1983	5	2 weeks at Stirling Royal
Inverness	1983	2	1 week at Raigmore Hospital
Longriggend	1984	3	1 week at Monklands General
			1 week at Hartwood Psychiatric
Penninghame	1984	1	2 weeks at Dumfries General
Perth	1983	3	1 week at Perth Royal
			1 week at Murray Psychiatric
Peterhead	1986*	6	3 weeks at Cornhill Psychiatric
Shotts	1985	1	2 weeks at Law Hospital
			2 weeks at Hartwood Psychiatric

Six officers to attend in a phase programme commencing 21 March 1986

Selection of nurse officers for more specialised further training is made in accordance with the identified needs of the particular establishments and individual nurse officers. For example, the Principal Nurse Officer at Cornton Vale attended a six month course in midwifery at Stobhill Hospital in 1983. From 1986, nursing staff will have an Annual Conference to be held at the Scottish Prison Service College which will provide an opportunity for prison nursing staff to discuss professional issues with nurses working in different environments.

APPENDIX 7

Memorandum by the Northern Ireland Office

THE PRISON MEDICAL SERVICE IN NORTHERN IRELAND

Northern Ireland Prison Population

1. Until the late 1960s the Northern Ireland prison population was very small in both absolute and relative terms, and medical services were provided by general practitioners working part-time in the prisons under contract to the department responsible for prison services—at that time the Ministry of Home Affairs.

In the late 1960s and early 1970s the prison population increased by a factor of almost as a result of civil disturbance and terrorist crime. New prisons were built. The prison population peaked at around 3,000 in 1978 and has since decreased to just under 2,000. The present ratio of prisoners to total population is about 125 per 100,000 compared with 96 per 100,000 in England and Wales.

2. Over two-thirds of Northern Ireland prisoners are convicted or charged with terrorist type crime. The non-terrorist prison population is still relatively small, representing about 40 per 100,000 of the total population.

3. Northern Ireland has no large conurbations, and, so far, no major hard drug problem. These and other factors have meant that the problems of psychiatric assessment of prisoners and handling those with psychological problems are proportionately less than in England. The medical services are concerned primarily with general health care of prison inmates. The particular problems associated with a predominantly terrorist prison population are substantially different from those experienced by the English PMS.

Northern Ireland Medical Civil Service

4. A number of medical services are directly provided by Government, including the Prison Medical Service, the Employment Medical Advisory Service, the Civil Service Medical Advisory Service, the Regional Medical Service. In England these operate as separate entities under the aegis of different departments. The corresponding services in Northern Ireland being so much smaller, the doctors who provide them are all on the staff of the Department of Health and Social Services in the Province.

Limitation of Prison Facilities

5. The NI Prison Service is small in absolute terms and is therefore limited in the specialist facilities that can be provided within it. There are, for example, no open prisons nor large special units for dealing with psychiatric problems. The PMS is consequently very dependent on Health Service staff and facilities for major medical services which could not be provided in the prisons.

Organisation and Structure of the Northern Ireland PMS

6. Until 1974 the Department responsible for the prisons was responsible also for prison medical services, relying for medical advice on the Chief Medical Officer, DHSS, and his medical staff. In 1974 the DHSS took over direct responsibility for providing the PMS, on an agency basis for the prison department—now the Northern Ireland Office. The NIO reimburses the DHSS for the expenditure involved. While DHSS is responsible for both the PMS and for the Health and Personal Social Services in Northern Ireland, they are separate services: the PMS is not provided as part of the HPSS.

Headquarters Staffing

7. The CMO is professional head of the PMS. A Deputy Chief Medical Officer has managerial responsibility for the service among other duties. There is a Principal Medical Officer post at DHSS HQ whose holder's responsibilities are entirely concerned with running the PMS.

Medical Staff in the Prisons

8. At the prisons there is a total establishment of 7 full-time doctors and 3 part-time doctors. Recommendations for staffing levels were made originally by the Director of the PMS in England, and were reviewed in 1983 by his successor, on whose recommendations the present authorised complement is based. A varying number of general practitioners also do sessional work in the prisons and some are available for medical emergencies outside office hours.

9. *Psychiatric Services* depend on psychiatrists working in the Health Service. Some consultant psychiatrists attend regularly at certain prisons and/or are available on requ

There is a part-time post of Consultant Adviser in forensic psychiatry in the PMS, normally filled by a Health Service consultant psychiatrist. There is a Senior Registrar post which is part of the Health Service psychiatric training programme. Senior Registrars fill this place on rotation each for a 6-month period. Recently arrangements have been made for 2 clinical psychologists to provide a total of one whole-time equivalent for prison work.

10. Dental Services

The Prison Dental Service was reorganised in March 1983. Since then it has been provided directly by the DHSS on an agency basis for the Northern Ireland Office.

Two Dental Officers and one Dental Surgery Assistant on the staff of the DHSS provide the main input. Out of hours emergency cover is given by 2 group dental practices.

In addition extra dental surgery assistance is provided by the Eastern Health and Social Services Board as and when necessary.

A full range of dental treatment similar to that in the Health Services is provided and any special services outside the experience of the Dental Officers is provided by a restorative consultant and an oral surgeon who attend the prison hospital when required.

The overall general health is the responsibility of the prison medical officer who refers those requiring dental care to the dental officer.

Overall Professional and Managerial responsibility for the Prison Dental Service lies with the Chief Dental Officer, DHSS.

11. *Opthalmic Services* are provided by visiting opticians.

12. Nursing Services

Four nurses on the staff of DHSS(NI) work full time in the prisons.

Most of the nursing support to medical staff is provided by Hospital Officers, as in the English PMS. They undergo the Home Office training course. Some also have formal nursing qualifications. In the prisons, they are on the staff of the prison Governor, but for day-to-day work report to the medical officer in charge.

13. Pharmaceutical Services

Pharmacists on the staff of the Health and Social Services Boards visit the prisons and oversee the ordering and maintenance of drugs and medicines.

14. Other Medical Services

Health Service consultants in most specialties attend the prisons on request. Prisoners may also be referred to Health Service hospitals—see paragraph 17.

Medical Staffing—Recruitment

15. It has always been extremely difficult to recruit doctors of suitable calibre and experience to the NI PMS. Recruitment to medical posts in the civil service is generally difficult largely because salaries compare unfavourably with those in the Health Service and the PMS presents particular problems. At present 5 full-time doctors are in post against an authorised complement of 7.

Plans have been made to increase the numbers of doctors working part time in the PMS on regular contract. It is hoped very soon to appoint P/T MOs to Magilligan and the YOC. The number of hospital officers in post is at present substantially below the authorised complement.

Health Care Facilities

16. Each penal establishment has a prison hospital in which prisoners can have such medical assessment and treatment and nursing care as does not require more extensive facilities. Three prisons have X-Ray units. Two units, within the prison hospitals at Belfast and Maze Prisons, are used for prisoners with psychiatric problems which can be handled by the staff and with the facilities available, under the direction of the visiting consultant psychiatrists.

17. Prisoners who need health care facilities beyond those available on site have to be referred to Health Service Hospitals. For acute or major illness, they are admitted to the appropriate hospital unit. There is a secure unit at a Northern Ireland hospital where medical and nursing provision is made by the Health Service with security provided by the RUC. It accommodates prisoners who need more elaborate services than can be provided in the prisons but not the facilities of acute or highly specialised hospital units.

Duties of Prison Doctors

18. The prison medical officer carries overall responsibility for the health of inmates. He provides their general medical care and obtains the services of other health professionals as required. The senior doctor in each prison advises the Governor on general health matters and supervises environmental and nutritional health of prisoners. The prison doctors report as required on prisoners' health to the prison administration and when necessary to the courts. While the prison doctor must acknowledge and respect the Governor's authority over prison organisation, discipline and security, health care of prisoners must follow the principles of medical ethics and the medical officer is professionally accountable not to the Governor or the NIO but to the Chief Medical Officer of the DHSS.

Special Problems

19. The majority of Northern Ireland prisoners are committed terrorists and members of paramilitary organisations. Many of them engage in organised activities within the prison intended to disrupt the organisation, embarrass the authorities and achieve propaganda advantages. Their attitudes and activities pose particular problems for those charged with their health care. Security requirements and special security measures in NI prisons also cause difficulties in operating medical services.

20. In addition to these continuing problems, there have been particular episodes and campaigns including the dirty protest at the Maze Prison and organised mass hunger strikes at Maze and Magilligan Prisons, which have posed unique difficulties for medical and support staff.

21. Finally it should be mentioned that medical practice in NI prisons always receives considerable public interest, is liable to be the subject of hostile propaganda and has on occasions (as in the Maze hunger strikes) been subject to inspectorial visits from numerous outside bodies including the International Red Cross.

Relationships with other Services

22. The PMS in Northern Ireland has always enjoyed a very high level of co-operation from staff in the Health and Personal Social Services on which it is very dependent. This co-operation is helped by the relatively small size of the services with consequently short lines of communication and (it is believed) by the fact that the one department has responsibility for both services.

23. The Northern Ireland structure, wherein DHSS runs the PMS as an agent of the NIO requires and in practice has obtained good communication and a high level of co-operation between officers of the 2 departments. Acknowledgement should also be made of the valuable help and advice given by the Home Office and particularly by successive Directors of the English PMS.

APPENDIX 8

Memorandum by Regional Medical Officers

The Regional Medical Officers of the 14 NHS Regions and their predecessors with the Regional Hospital Boards have been associated with the work of the Prison Medical Service since 1948. They have responded to requests from Prison Authorities to provide specialist services from the National Health Service, in some cases arranging regular visits to prisons by Consultant Psychiatrists. The work of Regional Medical Officers has also embraced the difficult interface between the NHS, prisons and courts over the arrangements for treating offenders with psychiatric disorders.

There are several areas in which RMOs wish to submit evidence to the Social Services Committee. The first of these is primary care, the second is the organisation of specialist services for prisoners, the third is the field of public health, and the last concerns postgraduate training for prison medical officers.

In the broadest terms RMOs believe the committee should aim for closer links with the NHS including the Family Practitioner (G.P.) Services. Changes in this direction should improve the quality of the prison medical services and of advice to the courts on offenders, also be seen by the public to introduce a beneficial element of external monitoring into the prisons.

Primary Medical Care

The Committee will be considering the choices open to it for the provision of primary medical care services to sick prisoners. One option is to depend substantially on "generalist" prison medical officers, and to ensure that those selected have appropriate clinical training to do the job. An alternative is, nevertheless, to extend the links with FPC doctors (G.Ps.) which have already developed in some areas, and move towards an NHS based service for sick prisoners and the initial examination of prisoners. This would have the advantage of providing clinical treatment for prisoners through doctors who are independent of the prison managers. This independence might be seen as a disincentive by prison managers but we believe it could be regarded as a source of valuable external monitoring by other parties.

A policy decision to transfer responsibility for primary care to NHS general practitioners will simplify consideration of the selection and training of prison medical officers, who cannot realistically have expertise in primary care and psychiatry, as well as having training and experience in public health, environmental health and the control of communicable diseases.

Specialist Medical Care

From time to time prisoners require a wide range of specialist services in connection with accidents and the investigation or treatment of medical or surgical illness. These services can continue to be made available from the NHS on an "as required" basis, and sick prisoners can be treated in local hospitals when prison hospitals are not appropriate. We believe, however, that the incidence of mental disorder amongst offenders and the need for psychiatric reports to the courts and prison authorities is high enough to warrant the *regular* attendance of consultant psychiatrists at all prisons.

We consider that collaboration with the NHS in the field of psychiatry can be improved. At present the prison authorities advertise for and recruit their own visiting psychiatrists. Such posts are frequently filled by local NHS psychiatrists but in some cases the separate recruitment by the prison authorities leads to the appointment of retired doctors. In our view it would be better if the requirements of the prison service for consultant psychiatrists were planned in collaboration with the NHS. One option would be to make joint appointments between the prisons and local psychiatric services. The alternative would be to arrange with the NHS that the necessary sessions in the prison service would be provided as an integral part of the job description of an NHS psychiatrist working in the locality. Close integration with the NHS services in this way will offer the best prospect of reliable

advice to the courts—the local psychiatrist will be fully conversant with the range an suitability of NHS facilities for the care of mentally disordered offenders.

The provision of psychiatric reports on offenders will be time consuming for visitin consultant psychiatrists, but the service by visiting psychiatrists should go further an include regular clinics for treatment and support to prisoners with a mental disorder whic is not sufficient to warrant their removal to a psychiatric hospital.

In recent years, the specialisation of "forensic" psychiatry has taken place in the NH Regions. The number of these specialist posts is, nevertheless, small, and their expertis must be available to all prisons, remand centres and "special" Hospitals throughout the NHS Regions. It would not be practicable for them to provide the *day to day* psychiatri sessions to prisons which we have recommended above. They remain an important secon line of advice on difficult cases.

Public Health

The advent of "new" infectious diseases like AIDS has added an urgency to th establishment of clear cut lines of responsibility for public health. Uncertainty over th precise responsibilities for public health matters of Regional and District Medical Office (NHS) was highlighted in the "Stanley Royd" Report this year, on an outbreak of foo poisoning in a hospital (HMSO Cmnd 9716). Subsequently, government action has bee taken to remove from hospitals their Crown exemption from the food hygiene regulation The Committee may wish to consider the implications of these developments for the prisc service.

We understand that at present, the formal responsibility for the inspection of premis in connection with food hygiene lies with the prison medical officer. It is for consider tion that Crown exemption should now be removed from the prisons.

Prison medical officers also have responsibility for the investigation and manageme of incidents of infectious disease in the prison though they will generally take advi from the Public Health Laboratory Service or the local District Medical Officer. We ca see that it would be difficult to transfer to NHS employees, the formal responsibility f dealing with incidents of infectious disease in a prison. The closed environment prisons will also produce stresses and health risks for prisoners and staff which are n usual in other institutions. In these circumstances it will probably be best to retain cadre of full-time prison medical officers with particular responsibilities across the whc field of public health in prisons. Their duties would also include monitoring and advisi on the health and health needs of the prison population and they could retain coordinating role for NHS services provided to the prison by General Practitioners a Hospital Specialists.

Postgraduate Medical Education

A decision needs to be made about the role of prison medical Officers. They cannot experts in several different fields of medicine. Once decisions are reached about t precise role and responsibilities of prison medical officers and the involvement of NH doctors in prison medicine, it will be possible to plan the necessary programmes for the ongoing medical education. Each group of doctors involved in prison medicine will ne further education not only to ensure that high standards are maintained in their clini work but also to update them on legislative and other organisational changes affecti prisoners and prison authorities. For some of these purposes the Home Office m continue to provide "central" training, but for many aspects of this work the establish postgraduate medical education centres at District Hospitals could be used. This w bring together general practitioners, specialists, and prison doctors and so contribute the development of good liaison between the prison authorities and the NHS.

APPENDIX 9

Memorandum by the Institute of Psychiatry

1. Introduction

1.1. The Institute of Psychiatry welcomes this opportunity to present its views on the Prison Medical Service to the House of Commons. We draw attention to the article recently published by one of us "Psychiatry and the Prison Medical Service" which is appended to this document* and which we endorse.

1.2. Our evidence is exclusively concerned with the Prison Medical Service of England and Wales. We have no first hand knowledge of prison medical matters in N. Ireland.

1.3. Our evidence will concentrate upon psychiatric matters, but we are aware that prison nursing services are central to prison health care, and that prison psychology services could also play an important role. We are also aware that the Prison Medical Service has responsibilities beyond psychiatry. Such other medical matters are briefly touched upon where we believe they have a bearing on psychiatric or administrative matters.

1.4. The Prison Service is currently suffering from two major difficulties, overcrowding, and isolation from other public services. We will make recommendations which could ameliorate these problems for prison doctors. To do this we will briefly introduce seven topics which we think the Social Services Committee should address in relation to the Prison Medical Service; we will then make some specific recommendations.

1.5. Prison doctors spend a lot of their time dealing with mentally abnormal offenders whether these are remanded or sentenced prisoners. Such people move in and out of the prison system and usually present long term management problems. It is fallacious therefore to consider prison psychiatry in isolation. Improved services in the NHS and improved connections between the Prison Medical Service and the NHS will reduce difficulties for prison doctors. Doctors working in prison require training; such training is not and cannot ever be adequately provided exclusively within the prisons. Similarly forensic psychiatrists working for the DHSS or the NHS need close contact with prisons and prison doctors, their patients move in and out of the penal system, they are needed to assess prisoners, and they may give treatment services within prisons to selected groups of prisoners. Comments will therefore be made about NHS and university services where appropriate.

2. Structure of Prison Medical Service

2.1. There has been a long debate about the administrative arrangements for prison medicine. In particular there have been arguments for and against amalgamating the Prison Medical Service with the National Health Service. We are persuaded that the arguments set out by Gunn for a separate Prison Medical Service, with its own Special Health Authority, ultimately responsible to the Secretary of State for Social Services, is the best current proposal.

2.2. A Special Health Authority would remove some of the isolation of the Prison Medical Service, it would give greater autonomy to the Director of the Prison Medical Service and his colleagues, it would ensure a budget which was separate both from the Home Office budget and from the rest of the National Health Service, and it would create a new interest in the health and care of prisoners. Above all it would strongly encourage health ministers to plan for psychiatry services as a whole rather than discounting patients in prison. In other words it would provide an incentive for efficient and effective management of an extremely difficult and sometimes worrying group of people, an incentive which does not fully exist when two major spending Departments are each looking to the other for resources.

3. Numbers of Medical Remands

3.1. There is general agreement that prison doctors are overstretched at the present time. One solution to this would be to increase the establishment of the Prison Medical Service,

* Not printed. 'Psychiatry and the Prison Medical Service', by Professor John Gunn, published in 'Secure Provision', Ed. Larry Gostin, Tavistock Publications, London.

but this solution would be quite expensive and would not take into account the difficultie which the service has constantly had in recruiting sufficient numbers of good calibr medical staff to its current establishment or the point made earlier (1.3) about interactio with other services. A more practical approach would be a national policy of significantl reducing the numbers of individuals remanded into custody, particularly those remande into custody for medical reports. Such a policy would of course have implications fa beyond the prison service, but very few can be satisfied with the current arrangements whic are almost unique to the United Kingdom, whereby the remand services in prisons are use as large scale clinical assessment centres for our courts. Even on a cost effectiveness bas the system is highly inefficient. Bowden (1978) showed that in London only 13 per cent o men remanded into custody for medical reports were received into hospital care.

3.2. Prison doctors are currently powerless to alter this situation. They therefore nee assistance by the provision of proper court reporting services within the National Healt Service. The recent Mental Health Act went some way towards encouraging courts t remand more cases to hospital for assessment, but legislation alone is insufficien Legislation does not produce changes in attitudes, nor new resources within the Nation Health Service. An expansion of forensic psychiatry services in terms of consultants, trainc consultants, and nursing staff is a basic requirement as well, if more patients are to be take

3.3. A simple immediate change which could assist with this problem would be th introduction of centralised and computerised court records so that doctors, probatic officers, and justices alike could see whether an accused has had a previous medical report(to court, how many, where, and when.

3.4. It might also be wise to try some experiments. One proposal which is controversi among us but is the kind of research (see 8) which the Prison Medical Service could t undertaking, is to attach a prison doctor to a large court for a period to see if bri assessments from him or her produce fewer remands in custody and/or more NH disposals.

4. Resources

4.1. We have already argued (3.1.) that a simple linear response of resources to curre demand would not be entirely appropriate as far as the Prison Medical Service is concerne There is also the need to reduce demand considerably. To do this will have implications f NHS services (see paras 1.3., and 3.2.). Experience shows that these are fully stretched present and it is likely that a shortage of NHS facilities is still playing a small role increasing the prison burden. A slow gradual expansion of NHS services for mental abnormal offenders should be government policy. For example when the first 1,000 beds f medium security services were authorised an undertaking was given to review the need f the second 1,000 beds (as recommended by the Butler Committee) as soon as the first 1,0(beds were completed. This undertaking will soon need to be honoured.

4.2. Even if the numbers of prisoners, especially remand prisoners were marked reduced there would probably still be a case for a small expansion in the Prison Medic Service to cater for some of the proposals here such as training posts, court docto experimental units and the like.

4.3. An immediate problem is training resources. Prison medical training resources w be mentioned in para 6.2. but it should also be noted that the Royal College of Psychiatri is collecting evidence which clearly suggests that the present programme of consultant po in forensic psychiatry cannot be met by the training posts which currently exist. This nee urgent attention from the Central Manpower Committee of the NHS.

4.4. A related problem which is usually ignored in these matters is the Univers component to training in forensic psychiatry. Medical schools are the main centres teaching and research in any medical subject. In spite of a commitment to expansion forensic psychiatry, which we believe can include Prison Medicine there are only t university funded posts in forensic psychiatry in England and Wales, both here at t Institute of Psychiatry. The Department of Education and Science should be urged monitor its funding policies in order to keep University funding in step to some extent, w varying medical demands.

5. Prison Conditions

5.1. There is no dispute that our prisons are overcrowded, outmoded, and bordering on the insanitary and inhumane. Prisoners and staff alike have to cope with conditions which would not be allowed in private establishments. It is a remarkable tribute to prison staff, especially prison doctors, that major epidemics of infectious diseases have not been a problem in contemporary prisons. Nevertheless the overcrowded and demoralising conditions produce severe mental health problems for some prisoners and probably exacerbate the control and management of difficult men.

5.2. Hygiene is currently one of the responsibilities of the prison doctor. We believe that standards of health and safety should reach at least as high a standard in prisons as they do in shops, factories, community homes, and the like. This does not happen at the moment because Crown property is immune from the ordinary local authority regulations which regulate these matters in other properties. Removal of Crown immunity, in this respect, would mean that prison hygiene would become the responsibility of the relevant local authority. This in turn would have three beneficial effects. It would relieve prison doctors of a burden, it would ensure that prisons are kept within ordinary public health regulations, e.g. in respect of overcrowding, and it would bring another public body in official contact with the prison service.

6. Training

6.1. Prison doctors undertake a job that is different from any other branch of medicine. Nevertheless they incorporate into that job skills of the community physician, the general practitioner, and the psychiatrist. Currently they are not trained formally in prison medicine as a whole or any of these three components. We believe this contributes greatly to their isolation and difficulties and we urge most strongly that urgent attention is given to the training of prison doctors. Attention should be given to all three spheres of education capitalising where possible on connections and collaboration with existing university and National Health Service training schemes. We will confine ourselves to comments about training in psychiatry.

6.2. Some prison doctors should have a specialist training in psychiatry in order to prepare them for the assessment and treatment work in this field which will undoubtedly always be required of prison doctors. Postgraduate psychiatric training in the National Health Service normally takes 6–7 years and it is undertaken in two stages. The first stage is three years of general psychiatric training leading to Membership of the Royal College of Psychiatrists by examination, then a further period of 3–4 years in one of the five major specialties of psychiatry (general psychiatry, child psychiatry, forensic psychiatry, mental handicap psychiatry, or psychotherapy), at which point the trainee will seek a consultant post by competitive appointment. This intensity of training is probably not appropriate for members of the Prison Medical Service, but the current policy is to recruit some doctors, where possible, who have the MRCPsych qualification. Some doctors in the prison service could be trained to that level within service, provided there was either an opportunity for them to have study leave to join approved training programmes within the National Health Service, or rotational training programmes established between the Prison Medical Service and the National Health Service in selected centres. This latter possibility would be useful in two ways. It would of course give prison doctors experience within the National Health Service, but just as importantly it would give National Health Service trainees experience within the prison system. For some prison doctors, those going on to senior posts for example, it might be appropriate to have at least some higher psychiatric training (i.e. post Membership of the College at a senior registrar level in the NHS), this too could be provided on a rotational basis in selected centres. Such training should not be confined to Special Hospitals as community psychiatry is also vital.

6.3. The Institute of Psychiatry has the largest training scheme in forensic psychiatry in the United Kingdom, it already has good working relationships at a consultant and trainee level with prisons at Brixton, Holloway, and Winchester. It further has good informal working relationships with the Directorate of the Prison Medical Service. We believe that we are in a position to do more than make suggestions for others to carry out, we believe that we can make a substantial offer to the Prison Medical Service in respect of training, an offer which would not be particularly expensive but which would simply require a re-organisation

of some prisoner doctor posts and some negotiation between the Prison Medical Service and the Institute of Psychiatry including the Joint Bethlem Maudsley Hospital. We would like to offer the opportunity of developing two pre-membership (registrar) and one post-membership (senior registrar) rotational posts to join the current training schemes which we operate. We envisage that such posts would be largely concerned with clinical work within the prisons, and under the supervision of selected consultants there, but would also provide opportunities for trainee prison doctors to work within the NHS environment for specified periods so that they could learn something of modern community psychiatry. We already have the successful experience of providing a joint training scheme between the Bethlem Maudsley Hospital and Broadmoor Hospital (a DHSS hospital).

6.4. If these proposals were unacceptable we could still offer places to prison doctors within our training schemes for specified periods, on a clinical associate (fee paying) basis but we would regard this as less satisfactory.

7. Recruitment

7.1. The key issue of recruitment to the Prison Medical Service is hardly ever discussed outside the Home Office, but our informal contacts make it clear that it is a source of considerable anxiety to senior prison doctors. We believe this matter can only be solved by some of the remedies we are suggesting here which include better contacts with the National Health Service, a more coherently organised career structure for prison doctors, and a training scheme. We also believe that recruitment from outside should not be confined to the lower ranks of the service. There is currently the view that senior prison doctors have an expertise which can only be acquired by progressing slowly through the ranks. This has some truth within it and such promotion should not be discouraged, but considering the lack of formal training for prison doctors and the lack of a specialised discipline of prison medicine, it is wrong to be totally exclusive as is currently the case. Talented well trained doctors should be able to move from the National Health Service to the Prison Medical Service and vice versa. Substantial testimony to this is given by the current Director of the Prison Medical Service who, exceptionally, was recruited from outside the ranks of prison doctors and is clearly a great success in the post.

8. Research

8.1. All branches of medicine need a knowledge base. Prison medicine can obviously draw on other branches of medicine for information, but there are specific questions of epidemiology, management, and the like which are peculiar to prison medicine. We must increase our knowledge of these matters if we are to improve services. Research is also a fundamental way of reducing isolation and improving standards.

8.2. In the past a small amount of Home Office Research Unit money has been made available for prison medical research. This has largely gone to the Forensic Psychiatry Section at the Institute of Psychiatry. Important reports, such as the book describing prison psychiatric services, especially Grendon prison (Gunn et al, 1974), have emerged as a result of this research. In recent years funding has largely dried up in this arena and research which we would want to undertake using funds from other sources, such as the Medical Research Council, has become difficult because of a new Prison Department reluctance to welcome outside research workers.

8.3. It is vital that more funding is given for prison medical research, and that collaboration between the Prison Medical Service and universities is actively encouraged. Once again we would like to offer an opportunity to the Prison Medical Service which is relatively cheap. We would suggest the establishment of a joint lecturer in forensic psychiatry between the Home Office and the Institute of Psychiatry. The lecturer would have some clinical duties within the prisons, but his main tasks would be to initiate and steer research within the Prison Medical Service, and to participate in the training of the prison doctors outlined above. Joint lectureship is probably a misnomer in that current government policy has ensured that there is no university funding whatsoever available for such a venture, but a similar arrangement with the Department of Health in respect of Broadmoor hospital has already been implemented and we believe this could be achieved with the Prison Medical Service if the Home Office could fund the whole post.

8.4. The research that needs to be undertaken is wide-ranging and various. The epidemiology of mental disorder in prisons obviously needs close understanding and monitoring. We have already suggested an experiment (para 3.4) in which prison doctors could be available to courts rather like probation officers are at present. A further important experiment was suggested by the Butler Committee (Home Office, DHSS 1975) when they proposed special training units for the treatment of psychopathic prisoners with different types of experimental unit being compared one with another. The potential list of research projects is extensive.

9. Recommendations

i The Prison Medical Service should be administered by a Special Health Authority responsible to the Secretary of State for Social Services. (Section 2)
ii The Prison Department should lose its Crown immunity from health and safety regulations. (para 5.2)
iii All prison doctor posts, including middle and senior grades should be open to free competition. (para 7.1)
iv Rotational training posts should be established between one or more prisons and the Institute of Psychiatry rotational training schemes at both a pre-MRCPsych (2 posts) and a post-MRCPsych (1 post) level. (para 6.3)
v Forensic psychiatry services in the National Health Service should be slowly increased, in particular the university component of these services should be sharply improved. (Section 4).
vi Prison medicine should have a regular allocation of research funds. (para 8.3)
vii University departments should be actively encouraged to undertake research into prison medical questions. (para 8.3)
viii A joint clinical lectureship should be established between the Home Office and the Institute of Psychiatry. (para 8.3)
ix The Prison Medical Service should try out a series of new schemes on an experimental basis. The schemes could include a central register of court report requests, a court doctor service, one or more training units for psychopathic prisoners. (para 8.4)

APPENDIX 10

Supplementary memorandum by the Institution of Professional Civil Servants

1. Introduction

1.1. The evidence submitted by the Institution in January 1986 focused on the organisation and structure of the Prison Medical Service and made recommendations on pay and gradings, staffing, facilities, resources, medical records, training, management, and the relationship of the PMS to the NHS. This paper dealt only with medical personnel.

1.2. The present submission may be regarded as an adjunct to the previous IPCS evidence, dealing as it does with the interface between medical and psychological services within the Prison Department.

2. Prison Psychological Services

2.1. The Directorate of Psychological Services (DPS) provides specialist input to the Home Office Prison Department. This ranges from diagnostic work, through inmate treatment and training and staff training, to research and advice on management issues, and assistance with organisational change and development. As at March 1985, the Directorate—outside of Headquarters, Regional Offices and the Prison Service College—comprises 11 Principal Psychologists, 53 Senior and Basic Grade Psychologists, and 26 Psychological Assistants. These Prison Department staff are based in 26 establishments but many have a visiting commitment to neighbouring institutions. Psychologists join the Home Office Prison Department as graduate entrants: those deployed to prison establishments include a small number of clinical psychologists, qualified through post-graduate training.

2.2. The first psychologists recruited to the prison service at the end of the 1940s we employed mainly to help governors and medical officers with the psychological assessme of prisoners for reports to courts and for the allocation of prisoners to different types establishments. Since the early 1960s, their role has widened to embrace the evaluation treatment regimes and broader management services. The prison psychological and medic services are managed as separate Directorates. Prison psychologists are a distinc professional group offering a wide range of specialist services to the Department.

2.3. Psychological work with inmates (including assessment, forensic, and clinic services) nevertheless continues to be a major feature of the work of the Directorate Psychological Services. Clinical services requested for remand cases (particularly those of serious nature) and for work with the mentally ill are provided to the extent that resourc allow. Most psychological intervention, however, centres on inmates who are not mental ill and concerns offending, disruptive, or coping behaviours.

2.4. There are a number of psychological and, more broadly, educational inputs which c not fall within an exclusively medical or clinical framework. These include social and li skills training, attitude modification, relaxation techniques and anger control, sex therap rehabilitation of drug addicts and alcoholics, individual counselling, and groupwo techniques. New entrant psychologists are trained in aspects of work with inmates and psychological assessment.

2.5. It is worth noting that much of the psychological work with inmates is developme tal, fuelling the work of both clinical colleagues and non-medical personnel in the pris service.

3. Clinical Psychological Resources

3.1. Most involvements with inmates do not necessitate a clinical qualification. This also true of psychological and intellectual assessments for court reports, institutio procedures, and reports to the Parole Board. Indeed, Psychological Assistants m administer psychometric test materials under the supervision of a qualified psychologi Clinical psychologists are nevertheless being bought in by the PMS from outside t Department for assessment work in establishments where prison psychologists are not full-time post or where resources do not allow. The Institution maintains that the buying of consultants should not be encouraged, particularly as a prison psychological servi exists.

3.2. Like their colleagues in the prison psychological service, the small number clinically qualified psychologists offers a range of services to the Home Office Pris Department. These can involve diagnostic assessment and intervention with the mentally bu' certainly extend to the treatment of inmates who are not classified in this way. Clini psychologists too have wider skills developed in the institutional setting and can advise a train other staff in aspects of systems, regime design and evaluative research. The same c be said of NHS psychologists whose professional training equips them to provide servi far wider than the performance of assessments and treatment on psychiatrically ill patie by which they are frequently stereotyped. Psychologists in the NHS are organised a profession separate from doctors, usually with independent accountability and resourc District or specialist teams are led by Top Grade clinical psychologists.

3.3. It has been suggested that clinical psychologists in the Home Office Pris Department should be subsumed under the PMS although this proposal runs counter almost 40 years' professional development in the prison service and would be at odds w trends in the NHS. Apart from that relatively small domain of clinical treatments offered the mentally ill in prison establishments (where it is likely that medical officers will contin to assume supervision of cases), there is no legitimacy in expecting one profession to over the other. Although it may be superficially attractive for clinical psychologists to be link with an overt treatment agency which has strong historical roots, the utility of such a mo is highly questionable. Organisation of additional clinical resources and the appointment the equivalent of Top Grade psychologists would galvanize clinical input and might attr clinical psychologists to the service: but a proposal that psychologists should work doctors might have the opposite effect, especially if the view of their contribution w limited to psychometric assessment and intervention only with the mentally ill. Certainly

greater number of clinically qualified psychologists needs to be recruited and retained by the Department to underpin a full range of services. The phsychological directorate provides the appropriate professional oversight for clinical psychologists and would be in a position to provide an efficient, flexible service to the Home Office Prison Department.

3.4. Part of this efficiency stems from applying the skills of clinical and other psychologists to the whole spectrum of routines, problems and developments in establishments. It also stems from the interchange of techniques and research evidence concerning psychological principles which is conducted in the Directorate of Psychological Services. It rests on the wider remit of working with inmates in which the majority of prison psychologists is involved and which applies to other than just the mentally ill. It assumes a suitable management structure and more satisfactory career prospects for all prison psychologists (including the clinically qualified) within the larger professional group. This in turn would enhance the Department's retention of full-time, experienced clinical psychologists.

4. Interface Between Medical and Psychological Personnel

4.1. In more general terms, the Home Office Prison Department needs machinery for the clarification of responsibilities and the promotion of collaboration between medical officers and psychologists. More than one Departmental review has recommended that the nature of the interface between medical and psychological services be clarified but this matter still awaits resolution by the PMS and the Directorate of Psychological Services. A recent Rayner-type Review of prison psychological services is currently under discussion within the Home Office Prison Department.

4.2. There is increasing accountability to prison governors for the medical personnel's operational input (particularly the non-treatment areas such as regime advice, parole and life assessment). Prison psychological staff also have dual accountability, along professional management lines and along operational lines via prison governors. This common thread of accountability should help to promote the concept of multi-disciplinary team working between professionals, including medical and psychological staff, within each establishment.

5. Summary

5.1. This submission may be regarded as an adjunct to the evidence submitted by the Institution of Professional Civil Servants in January 1986 [Paragraphs 1.1.–1.2.].

5.2. Psychological staff deliver a range of services to the Home Office Prison Department, including work with inmates. Most frequently, this centres not on the mentally ill but on offence or institutional behaviour and does not necessitate clinical qualifications [Paragraphs 2.1.–2.5.].

5.3. Clinically qualified psychologists should not be bought in from outside the Home Office Prison Department but a greater number should be recruited on a full-time basis [Paragraph 3.1].

5.4. Clinical psychologists in the prison service, like those working in the NHS, provide a range of services greater than assessment and treatment of the mentally ill. They should not be subsumed under the PMS but should continue to offer a full and flexible professional service to the Home Office Prison Department with the support and supervision of the Directorate of Psychological Services. The interchange of techniques and evidence concerning psychological principles in the prison setting and a fuller career structure are more likely in the larger professional group [Paragraphs 3.2.–3.4.].

5.5. A general clarification of the interface between medical officers and prison psychologists as two professional groups is required and multi-disciplinary team working should be encouraged in the prison service [Paragraphs 4.1.–4.2.].

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H.C. 73 i See H.C. 241
73 ii -iv " " "

SIXTH STANDING COMMITTEE ON STATUTORY INSTRUMENTS, &c.

MINUTES OF PROCEEDINGS

ON THE

DRAFT EMPLOYMENT SUBSIDIES ACT 1978 (RENEWAL) (GREAT BRITAIN) ORDER 1985

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SIXTH STANDING COMMITTEE ON STATUTORY INSTRUMENTS, &c.

DRAFT EMPLOYMENT SUBSIDIES ACT 1978 (RENEWAL) (GREAT BRITAIN) ORDER 1985—Referred to a Standing Committee on Statutory Instruments, &c. on 12th November 1985; allocated by Mr. Speaker to the Sixth Standing Committee on Statutory Instruments, &c. on 13th November.

The Committee was constituted as follows:—

Sir ANTHONY MEYER appointed Chairman, 13th November

Mr. Robert Atkins
Mr. Tony Banks
Sir Nicholas Bonsor
Mr. William Cash
Mr. Alan Clark
Mr. Michael Fallon
Mr. Bruce George
Mr. Conal Gregory
Mr. Jerry Hayes
Mr. Robert B. Jones
Mr. Greg Knight
Mr. Peter Lloyd
Mr. Andrew Mackay
Mr. George Park
Mr. Martin Redmond
Clare Short
Mr. Richard Wainwright
Mr. Michael Welsh

PROCEEDINGS OF THE COMMITTEE

Wednesday 20th November 1985

MEMBERS PRESENT

Sir ANTHONY MEYER, in the Chair

Sir Nicholas Bonsor
Mr. Alan Clark
Mr. Michael Fallon
Mr. Conal Gregory
Mr. Robert B. Jones
Mr. Greg Knight
Mr. Peter Lloyd
Mr. George Park
Mr. Martin Redmond
Clare Short
Mr. Michael Welsh

DRAFT EMPLOYMENT SUBSIDIES ACT 1978 (RENEWAL) (GREAT BRITAIN) ORDER 1985

Resolved, That the Committee has considered the draft Employment Subsidies Act 1978 (Renewal) (Great Britain) Order 1985.—(*Mr. Alan Clark.*)

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Bwrdd Henebion Cymru
Ancient Monuments Board for Wales

28th, 29th and 30th Annual Reports 1981/84

Cover photograph: An aerial view of
Castell Dinas Bran, near Llangollen, Clwyd.

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Bwrdd Henebion Cymru
Ancient Monuments Board for Wales

28th, 29th and 30th ANNUAL REPORTS 1981/84

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in pursuance of Section 23 of the
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BWRDD HENEBION CYMRU
ANCIENT MONUMENTS BOARD FOR WALES

To The Right Honourable Nicholas Edwards, M.P.
Secretary of State for Wales

SIR,

I have the honour to present Annual Reports of the Ancient Monuments Board for Wales for the period 1 January 1981 to 30 April 1984. With your permission, the Board's Reports will in future be based on financial years rather than calendar years as in the past, as this will facilitate the provision of budgetary details as appropriate.

As you know, the Board is constituted under the provisions of section 22 of the Ancient Monuments and Archaeological Areas Act 1979 and is charged with providing advice to you in connection with matters covered by that Act. In appointing its members, you take account of the requirement to represent those bodies specified in section 22(4) of the Act.

The membership of the Board has changed during the period of these Reports and I am sure you would wish me to pay tribute to the work carried out by previous members, particularly my eminent predecessor, the late Sir Idris Foster, under whose Chairmanship the Board operated for the period covered by 2 of the 3 Reports which are now presented. It was with great sadness that we heard of his death. The other members who served during the period of these reports and to whom we also pay tribute are: Dr. Ilid Anthony, Mrs. Helen Ramage, Dr. A. J. Taylor, Peter Smith, Esq. and Dr. H. N. Savory.

The present membership is as follows:—

Chairman:	Professor Glanmor Williams, C.B.E., M.A., D.Litt., F.S.A., F.R.Hist.S.
Members:	Professor R. J. C. Atkinson, C.B.E., M.A., F.S.A.
	G. C. Boon, Esq., B.A., F.S.A., F.R.Hist.S., F.R.N.S.
	Professor R. Davies, B.A., D.Phil., F.R.Hist.S.
	R. B. Heaton, Esq., B.Arch., F.R.I.B.A.
	The Rt. Hon. Lord Kenyon, C.B.E., D.L., LL.D., F.S.A.
	D. Moore, Esq., R.D., B.A., M.Ed., F.S.A.
Secretary:	R. J. Bolus, Esq.
Assistant Secretary:	G. A. Willis, Esq.

The Board has gone through a period of intense change in recent years—in membership, organisation and function. These changes are referred to in these Reports. With the imminent establishment of "Cadw: Welsh Historic

Monuments'' to administer your ancient monuments' and historic buildings' functions, the programme of innovation and change has not yet been completed. We look forward to the new challenges ahead and will continue to provide you with advice as required in furtherance of our joint aim of conserving and promoting the ancient monuments which are so important to our Welsh heritage.

GLANMOR WILLIAMS

Chairman

ANCIENT MONUMENTS BOARD FOR WALES
28th ANNUAL REPORT: 1 JANUARY—31 DECEMBER 1981

1. The Board met twice during the year. The first meeting was at Gregynog in Powys in June when members visited 4 monuments in your care, namely Tŷ-Mawr, Dyfi Furnace and Montgomery and Dolforwyn Castles. The second meeting was held in Castell Coch near Cardiff in November.

Tŷ-Mawr, Castell Caereinion, Powys

2. Medieval aisled houses such as this are rare and because of its outstanding importance it was taken into your care by purchase from the Powis Estate. The building underwent massive alteration during its life and the surviving framework is in a critical condition.

3. The choices for its preservation present unusual difficulty and the Board considered the various problems at length. It formed the opinion that it would not be feasible to preserve and display the building on its present site, and recommended its transfer to the Welsh Folk Museum which is willing to remove it to St. Fagans and reconstruct it there in its original form.

Dyfi Furnace, Near Machynlleth (Plate 1)

4. This charcoal-fired blast furnace was built in the 18th Century and is one of the few surviving examples of the older method of production whose usefulness declined when coke-fired furnaces came into general use. The water power was later employed for a sawmill. The site was placed in your care by the Royal Society for the Protection of Birds.

5. The Board supports your programme of consolidation and reroofing. On their visit members were impressed by the work already carried out including the renovation of the water-wheel to full working order.

Montgomery Castle (Plate 5)

6. The Castle was founded in 1223 by King Henry III and it played an important part in the conflicts of the 13th Century. An elaborate brick house was built within the walls in the 17th Century. Both buildings were demolished after the Civil War and the ruins are now in your care.

7. The necessary extensive excavations have revealed fresh archaeological data; and the conservation work, including the provision of new bridges, is impressive and has greatly improved both the appearance and access.

Dolforwyn Castle

8. This short-lived but important Welsh native castle was given to you by the late Dr. J. D. K. Lloyd, a former Chairman of this Board. Substantial

remains are now under the ground and the visible masonry is in poor condition. Urgent consolidation is required, together with major excavation. The Board has provided technical advice to your officials who are to carry out these important works.

Conwy Castle

9. The board examined the Welsh Office proposals for a new access and improved facilities but recommended that they should be deferred until a local authority study of traffic flow and pedestrianisation had been undertaken.

10. On the advice of the Board you have acquired an important section of land below the Castle wall which has for long been an eyesore because of its use by a scrap metal dealer and coal merchant. This action, when the site has been landscaped, will further enhance this major monument.

Scheduling

11. During the year the Board recommended 20 monuments for scheduling and one for de-scheduling. Details are given in Appendix 1 of this Report.

Rescue Archaeology

12. The Board's Rescue Sub-Committee met 3 times during the year. It recommended that the arrangements for reinstatement and compensation following Rescue excavation work be reviewed and clarified, and stressed the necessity for specialist examination of environmental evidence to continue following termination of the contract with University College, Cardiff. The problem of outstanding excavation reports was considered and the use of sanctions recommended in certain cases.

13. A statement of rescue work carried out during the year by the Archaeological Trusts in Wales is contained in Appendix 2 of this Report.

Legislation and Organisation

14. The Board noted that Parts 1 and 3 of the Ancient Monuments and Archaeological Areas Act 1979 came into operation in October. The Board welcomed in particular the introduction of "Scheduled Monument Consent" procedures whereby any works affecting scheduled monuments in Wales will require your consent.

APPENDIX No. 1

MONUMENTS RECOMMENDED FOR SCHEDULING

DYFED

Abergwili (SN 462 213)
A well preserved round barrow 200 metres W.S.W. of Felin-wen-Isaf.

Llangolman (SN 114 284)
Small standing stone 110 metres N.W. of Spring Gardens.

Llanddewi Brefi (SN 690 554)
Well preserved Cairns and Ringworks south of Bryn Rhudd.

Manorbier (SS 075 966)
Old Castle Head Promontory Fort.

Llangendeirne (SN 474 092)
Remains of a Blast Furnace at Pont Henry, C1620-1760.

GWYNEDD

Llandecwyn (SH 630 361)
Coety Bach Homestead.

Llandecwyn (SH 631 360)
Coety Mawr Round Hut and Enclosure.

Talsarnau (SH 616 329)
Round Hut Enclosure and Ancient Fields at Ffridd Fedw.

GWENT

Blaenavon and Llanfoist Mawr (SO 2706 0997, SO 2708 1003)
Carn y Defaid Round Cairns to Bronze Age Burial Mounds on the Blorenge.

Kemeys Inferior (ST 360 916)
Roman Site, Great Bulmore (extension of scheduled area).

MID GLAMORGAN

Maesteg (SS 849 918)
Remains of Blast Furnace and Engine House, Maesteg.

Merthyr Tydfil (SO 038 069)
Remains of Blast Furnace, Cyfarthfa Ironworks.

Vaynor (SO 018 100)
Daren Round Cairn, Taff Valley above Merthyr Tydfil.

WEST GLAMORGAN

Llanrhidian Hir (SS 553 961)
Penclawdd Sea Dock, Remains of early 19th Century tidal dock.

Neath (SN 868 104)
Remains of Blast Furnace at Banwen, two Blast Furnaces and Engine House.

Llanquicke/Cilybebyll (SN 737 051/737 047)
Ironworks, 650 metres W. of Cilybebyll.

Resolven (SN 825 018)
Remains of Charcoal Furnace at Melin Court.

Blaengwrach (SN 865 050)
Remains of Venallt Ironworks.

SOUTH GLAMORGAN

Ystradowen (ST 021 772)
Castell Tal-y-fan, Ystradowen, Medieval Castle and Earthwork Remains.

Barry (ST 099 665)
Cold Knap Roman Site, Roman Courtyard Building.

Llantwit Major (SS 983 684)
Boverton Place, Llantwit Major, 16th Century House now in ruins.

APPENDIX No. 2

RESCUE ARCHAEOLOGY WORK CARRIED OUT IN WALES IN 1981

CLWYD-POWYS ARCHAEOLOGICAL TRUST LTD.

Chairman: H. NOEL JERMAN, Esq., C.B.E., M.A., F.S.A.
Director: C. R. MUSSON, Esq., B.Arch.
Headquarters: 7a Church Street, Welshpool, Powys

Principal Excavations

(1) Collfryn hillslope enclosure, Llansantffraid-ym-Mechain, Powys. Continued excavation work.

(2) Pentre Farm Roman Site, Flint, Clwyd. Excavation and post-excavation work.

(3) Ring ditches and pit alignments at Four Crosses, near Welshpool, Powys. Commencement of excavation.

Surveys and other work

(4) Continued post-excavation work on earlier projects.

(5) Completion of field survey in the Brecon Beacons National Park.

(6) Continued aerial survey of plough-threatened sites in the northern-central Marches.

(7) Continued work on the Sites and Monuments Records for both counties.

DYFED ARCHAEOLOGICAL TRUST LTD.

Chairman: Professor W. F. GRIMES, C.B.E., M.A., D.Litt., F.S.A., F.M.A.
Director: D. G. BENSON, Esq., M.A.
Headquarters: The Old Palace, Abergwili, Carmarthen, Dyfed.

Principal Excavations

(1) Carmarthen. Priory Street. Continuing excavation within Roman Town in advance of housing development.

(2) Drim Camp. Llawhaden. Total excavation of small defended enclosure.

(3) Carne, Llanwnda. Excavation of Bronze Age 'burnt mound' subject to land improvement scheme.

(4) Parc Maen, Llangolman. Preliminary excavation on standing stone site subject to land improvement scheme.

(5) Llawhaden. Trial excavation on Iron Age/Romano-British enclosures, Dan-y-Coed and Woodside Camps.

(6) Carmarthen. Woods Row. Trial excavation on area of medieval town defences threatened by housing development.

(7) Carmarthen. Vicarage Garden. Trial excavation in advance of housing development within Roman Town.

Surveys and other work

(8) Salvage and survey work during commercial clearance of stone in several areas of north Pembrokeshire.

(9) Haverfordwest. Commencement of topographical and documentary survey in response to increase in re-development proposals.

(10) Salvage excavation of 'burnt mounds' at Llanon, uncovered during new road construction.

(11) Watching briefs in Bridge Street, Haverfordwest; Nott Square, Barclays Bank, and Church Street, Carmarthen; Whitland Abbey; Whitemill; and Lampeter Velfrey.

(12) Continued work on computer-based sites and monuments documentation and supplying of data to local Planning Authorities.

(13) Continued post-excavation work on earlier excavations.

(14) Compilation and assessment of archaeological data for Dyfed County Council Black Mountain District Plan.

GLAMORGAN-GWENT ARCHAEOLOGICAL TRUST LTD.

Chairman: H. N. SAVORY, M.A., D.Phil., F.S.A.

Director: G. DOWDELL, B.A., Dip.G.S. (Harl.)

Headquarters: 6 Prospect Place, Swansea, West Glamorgan SA1 1QP.

Principal Excavations

(1) Glan-y-Môr, Cold Knap, Barry. Further excavation of Roman building.

(2) Westward Corner, Barry. Excavation of a possible Iron Age settlement.

(3) Lodge Road, Caerleon. Trial excavation to locate the extent of Romano-British civilian settlements.

(4) 'Roman Gates', Caerleon. Completion of excavation on the Roman Legionary Fortress.

(5) 'Cae Castell', Rumney, Cardiff. Completion of excavation of the Medieval ringwork and castle.

(6) Arthur John Car Park, Cowbridge.
(7) Bear Barn, Cowbridge.
(8) 27 High Street, Cowbridge.
(9) 61 High Street, Cowbridge.
(10) 77 High Street, Cowbridge.
(11) Hopyard Meadow, Cowbridge.

} Excavations on the Roman and Medieval settlements.

(12) Margam Park, Port Talbot—a Roman road and possible stone cross base.

(13) Penrhiw Cradoc, Mountain Ash. Excavations on a group of small cairns.

Surveys and other work

(14) Monitoring of all planning applications before determination and liaison with Local Authorities on the archaeological implications of Development Plans continued.

(15) Surveys and aerial surveys watching briefs and salvage work entailing some 500 site visits and post-excavation work were undertaken during 1981.

(16) Updating and indexing continued of Sites and Monuments Record.

GWYNEDD ARCHAEOLOGICAL TRUST LTD.

Chairman: A. H. A. Hogg, Esq., C.B.E., D.Litt., F.S.A.

Director: R. B. White, Esq., B.A.

Headquarters: Deiniol Road, Bangor, Gwynedd

Principal Excavations

(1) Capel Eithin, Caerwen. Work was completed during a second season of excavation with particular emphasis on the early Christian cemetery.

(2) Excavation of a Circular Enclosure Settlement at Erw-wen, Harlech.

(3) Excavation of a Hut circle in advance of flooding at Cwm-Ystradllyn, Dolbenmaen.

Surveys and other work

(4) Provisions of planning control information on archaeological sites and areas for the Dwyfor District Council (Sites and Monuments Record).

ANCIENT MONUMENTS BOARD FOR WALES
29th ANNUAL REPORT: 1 JANUARY—31 DECEMBER 1982

1. During the period of this Report, the Board met 4 times—3 times in Cardiff and once in Haverfordwest. On the latter occasion members visited the Bishop's Palace at St. David's and the Priory at Haverfordwest which you had recently acquired and which is to be excavated and presented to the public following a major works' programme during the coming years.

Proposed Reorganisation of Ancient Monuments' and Historic Buildings' Work

2. The Board convened 2 meetings, in January and February, to thoroughly consider the consultation document issued by the Department of the Environment which you circulated under cover of a separate note to interested bodies in Wales.

3. The DOE paper proposed the amalgamation of the Ancient Monuments Board for England and the Historic Buildings Council for England in a new agency to which would be transferred most of the existing statutory responsibilities of the Secretary of State for the Environment in the field of ancient monuments and historic buildings. You sought the Board's views as to whether similar arrangements should be implemented in Wales.

4. After very careful thought and discussion, the Board concluded that a new statutory body along the lines proposed in England would not be appropriate in Wales. The different scale of the operation here; the different background, emphasis and organisation; and the fact that the existing framework in Wales showed no obvious signs of major defects mitigated against the implementation of the DOE proposals insofar as the Principality was concerned. However, the Board recognised that improvements could be effected within the existing statutory framework and wished to explore the scope for such improvements in a vigorous and constructive way.

5. Later in the year the Board welcomed your decision not to implement the statutory changes proposed in England and your intention to review the existing organisation in Wales along different lines.

Individual Cases

Tŷ Mawr, Castle Caereinion, Powys

6. The proposal to move this rare Medieval Aisled House to the National Folk Museum, St. Fagans as previously recommended by the Board, met with strong local objections. Fully recognising the need to consult widely and to explore every avenue in preserving and presenting Tŷ Mawr to best effect, the Board allowed a period for local and national interests to come up with valid options for the future. Meanwhile the building has been given temporary structural protection.

Caerleon Roman Baths

7. The Board warmly welcomed your decision to provide a protective building over the exposed remains of the Roman Baths at Caerleon. Upon completion, this project will rank as one of the most outstanding contributions in the field of conservation of Welsh monuments.

Tomen-y-Mur, Gwynedd

8. We noted with regret that the National Park Committee had decided not to proceed with the purchase of this site, as a consequence of the owner having increased the sale price.

Raglan Castle, Ticket Office

9. The Board examined the proposed design of the new ticket office for Raglan Castle and was content with the proposals.

St. David's Bishop's Palace, Dyfed (Plate 2)

10. Members of the Board visited the Bishop's Palace during June to inspect the site. As a result it was recommended that protective stone tiles be installed to protect the corbel heads, pending the outcome of trials with protective liquid.

Haverfordwest Priory, Dyfed

11. The Board visited this site in June and was able to appreciate the extent of the earth and rubble clearance works at the Priory. It was felt that following the full programme of work over the next few years this site would provide a very attractive monument for presentation to the public.

Scheduling

12. During the year the Board considered and recommended 22 monuments for scheduling and these are detailed in Appendix 1.

13. The Board also considered the position of the Pont Barker scheduled Ancient Monument (which had recently collapsed) and recommended its removal from the Schedule.

Ancient Monuments Board for England, Science Review Paper

14. This Review Paper was examined by the Board and detailed comments were submitted to the Ancient Monuments Board for England.

Rescue Archaeology

15. The Board's Rescue Archaeology Sub-Committee met during March and October 1982. It considered the problems of publication of excavation reports, including the Monograph Series. The Board members agreed that texts should be referred to the Welsh Office Inspectorate before publication—in cases where your Department would be contributing towards the publication costs.

16. The Sub-Committee also considered a paper on Sites and Monuments Records but felt there was no case for proceeding with the proposals.

17. A statement on rescue archaeology work carried out during the year in question by the Archaeological Trusts, appears at Appendix 2 of this Report.

APPENDIX No. 1

MONUMENTS RECOMMENDED FOR SCHEDULING

DYFED

Crinow (158-SN 129 142)
Clynpattel motte and bailey.

St. Davids (157-SM 766 257)
Standing stone N.W. of Trecenny Farm.

Pembroke (158-SM 976 017)
Monkton Priory dovecote.

Llanfynydd (146-SN 561 309)
Y Garn Ring Cairn.

Llanychaer (157-SN 017 342)
Iron Age Enclosure in Kilkiffeth Wood.

St. Ishmaels (157-SM 855 065)
Promontory Fort on Little Castle Head.

Maenclochog (158-SN 095 270)
Standing stone S. of Prysg Farm.

Whitchurch (157-SM 802 239)
Promontory Fort S. of Solva Harbour.

Newton North (158-SN 089 141)
Iron Age Hillslope Enclosure in Canaston Wood.

St. Ishmaels (157-SM 848 060)
Promontory Fort on Great Castle Head.

Puncheston (145-SN 001 322)
Iron Age/Romano-British settlement and field system on Fagwyr-fran Moor.

Bayvil (145-SN 113 418)
Enclosure site 70 m North of Post-coch Crossroad.

GWYNEDD

Llandecwyn (124-SH 635 362)
Maes y Caerau homestead.

Llanelltyd (124-SH 720 235)
Berth-lwyd and Cefn Coch gold mining complex.

Llandecwyn (125-SH 625 343 and SH 625 344)
Moel-y-Glo Homestead and Burnt Mound.

GWENT

Crucorney Fawr (161-SO 288 278)
Llanthony Priory (Definition of Scheduled Area).

Crucorney Fawr (161-SO 342 222)
Penbidwal Moated Site.

Llanvaches (171-ST 424 920)
Medieval deserted village at Talgarth.

MID GLAMORGAN

Merthyr (171-SO 038 071)
Pont-y-Cafnau Tramroad Bridge.

Tythegston (170-SS 851 835)
Cefn Cribwr ironworks.

WEST GLAMORGAN

Dyffryn Clydach (170-SS 737 978)
Neath Abbey ironworks (extended area).

POWYS

Llansantffraed Cwmdeuddwr (136-SN 967 677)
Tomen, Llansantffraid.

MONUMENT TO BE REMOVED FROM SCHEDULE

CLWYD

Corwen (125-SJ 044 437)
Pont Barker.

PLATE 1

Dyfi Furnace, near Machynlleth: after consolidation, showing the newly-restored waterwheel

PLATE 2

St. David's Bishop's Palace, Dyfed, seen from the west.

PLATE 3

Castell Dinas Bran, near Llangollen, Clwyd: consolidation work in progress in the area of the Hall.

PLATE 4

The motte and bailey Castle at Tomen y Rhodwydd, Llandegla, Clwyd: photograph taken as part of an aerial survey of Scheduled Ancient Monuments.

PLATE 5

Montgomery Castle, Powys. New bridges and consolidation work completed.

APPENDIX No. 2

RESCUE ARCHAEOLOGY WORK CARRIED OUT IN WALES IN 1982

GLAMORGAN-GWENT ARCHAEOLOGICAL TRUST LTD.

Chairman: H. N. SAVORY, M.A., D.Phil., F.S.A.
Director: G. DOWDELL, B.A., Dip.G.S. (Harl.)
Headquarters: 6 Prospect Place, Swansea, West Glamorgan

Principal Excavations

(1) Arthur John Car Park, Cowbridge. Excavations revealed a Romano-British bath-house with 3 main structural phases resulting in a total of 14 rooms.

(2) Hopyard Meadow, Cowbridge. Excavations revealed a Post-Medieval toll-house which superseded 3 small medieval houses of probable 14th century date.

(3) 27 High Street, Cowbridge. Demolition of outbuildings to reveal Medieval masonry, similar to that excavated at 77 High Street which represented the rear of the original building.

(4) 39 High Street, Cowbridge. Excavations revealed a stone-lined culvert of Post Medieval date.

(5) Bear Barn, Cowbridge. Excavations revealed a series of Post-Medieval buildings flanking the courtyard. Beneath these was a series of gullies and post holes of Romano-British date.

(6) Midland Bank, 61 High Street, Cowbridge. Excavations to the rear of the burgage plot revealed a section of medieval Town Wall; the position of the North Gate of the town and pier of medieval masonry of c.2 m height. Sealed below the Medieval layer was a rock-cut ditch 7-8 m wide and finds of Romano-British date.

(7) Woodstock Home, 83 High Street, Cowbridge. Examined foundations of Romano-British strip building (timber) dating to the 3rd or 4th century.

(8) Taynton Cottage, 23 High Street, Cowbridge. Foundations of the Medieval Town Wall located.

(9) Bear Field, Cowbridge. Magnetometer Survey carried out with assistance of University of Bradford School of Archaeological Sciences.

(10) Loughor, West Glamorgan. In May 1982 a 2 year project was commenced in advance of the destruction of parts of the Roman fort and medieval town by the proposed construction of the M4/Llanelli Link Road. The sites excavated were Upper Station House, 1 and 3 Dock Street, Lower Station House, the Castle Street site and Bwrw site.

(11) The White House, Cold Knap, Barry. Magnetometer Survey and excavations in advance of development.

(12) Priory House, Caerleon. Trial excavations.

(13) Orchard Site, Church Road, Chepstow. Trial works ahead of residential development, revealing finds and isolated Roman, Medieval and Post Medieval dates.

(14) Cosmeston, South Glamorgan. Exploratory work revealed 3 buildings undoubtedly associated with this Medieval Village.

(15) Llanfrynach, Nr. Cowbridge. Excavations revealed remains of 2 buildings which had apparently fallen into disrepair in the 15th Century.

(16) Rock Cottage, South Cornelly. Salvage work to reveal human skeletons found during the construction of an agricultural building resulted also in the positive identification of the ruins of a Medieval Chapel.

Surveys and watching briefs

(17) Clyne Valley Country Park, West Glamorgan. Trust staff assisted and advised Swansea City Council in the identification and preservation of a variety of industrial archaeological sites.

(18) Dowlais—Nelson Gas Pipeline. A survey and watching brief.

(19) Wye-Usk Transfer Scheme. Watching brief on route of pipeline between Monmouth and Caerleon.

(20) Venallt Iron Works, Glynneath, West Glamorgan. Survey and recording of remains.

(21) Marsh House, East Aberthaw, South Glamorgan. Trust staff assisted RCAHM (W) in surveying fortified tobacco warehouse.

(22) Watching Briefs. Trust staff were also involved in watching briefs, minor surveys and site visits and the updating and indexing continued on sites and monuments records.

(23) Planning. Monitoring of planning applications before determination, and liaison with Local Authority on the archaeological implications of local plans continued. Enquiries were made into the details of 506 developments and a direct archaeological response was required in 110 cases.

(24) Post Excavations. Post excavation and publication work on completed projects continues.

DYFED ARCHAEOLOGICAL TRUST LTD.

Chairman: Professor W. F. GRIMES, C.B.E., M.A., D.Litt., F.S.A., F.M.A.

Director: D. G. BENSON, Esq., M.A.

Headquarters: The Old Palace, Abergwili, Carmarthen, Dyfed

Principal Excavations

(1) Carmarthen, Priory Street. Excavation of area of Roman Town in advance of housing development.

(2) Dan-y-Coed, Llawhaden. Excavation of Iron Age/Romano-British defended enclosure prior to further damage by ploughing.

(3) Wood-side camp, Llawhaden. Excavation of Iron Age enclosure prior to further ploughing.

(4) Parc Maen, Llangolman. Excavation of Bronze Age burial and ritual complex prior to a land improvement scheme.

(5) Pen-y-Coed, Llangynog. Trial excavation on defended enclosure prior to land improvement scheme.

(6) Llanilar. Salvage excavations on Bronze Age cemetery prior to housing development.

(7) Carmarthen Friary. Preliminary excavations on Medieval Greyfriars in advance of superstore development.

Surveys and other work

(8) Watching brief on Welsh Water Authority works at Llandovery Roman Fort.

(9) Salvage/recording work at Cwm-brwyn, Llanddowror (Iron Age/Romano-British enclosure); St. Elvis, Solva (early Christian Site); Trawscoed Roman Fort; Llangeitho (Bronze Age burnt mound); St. Elvis, Solva (Neolithic Tomb); Newcastle Emlyn Castle.

(10) Continued work on computer-based Sites and Monuments Record.

(11) Continued post-excavation work on earlier excavations.

(12) Continued supply of information to District Planning Authorities for development control purposes and contributions to Local Plans.

CLWYD-POWYS ARCHAEOLOGICAL TRUST LTD.

Chairman: H. Noel Jerman, Esq., C.B.E., M.A., F.S.A.

Director: C. R. Musson, Esq., B.Arch.

Headquarters: 7a Church Street, Welshpool, Powys

Principal Excavations

(1) Collfryn, Llansantffraid-Ym-Mechain, Powys. Completion of excavation on a plough-threatened hill-slope settlement of Iron Age and Romano-British date.

(2) Four Crosses, Llandysilio, Powys. Excavation of Bronze Age ring ditches (burial mounds) and pit alignments (field system, as yet undated) in the Severn/Vyrnwy Valley north of Welshpool.

(3) Rhuddlan, Clwyd. Continued excavations on defences of supposed late Saxon *Cledemutha*.

(4) Smaller scale excavations at sites in both counties, including Dinorben and Rhuddlan in Clwyd and at Colwyn Castle and Beulah Roman Forts, Llansantffraid Cwmdeuddwr Motte and a site at Maesmelan, all in Powys.

Surveys and other work

(5) Continued work on publication texts for earlier excavations.

(6) Site visits and watching briefs in both counties; limited aerial survey of North Powys and South Clwyd.

(7) Continued work on the Sites and Monuments Records and development control procedures for both counties.

(8) Education and publicity work through talks, lectures, site visits, newspaper articles and publications.

GWYNEDD ARCHAEOLOGICAL TRUST LTD.

Chairman: A. H. A. HOGG, Esq., C.B.E., D.Litt., F.S.A.

Director: R. B. WHITE, Esq., B.A.

Headquarters: Deiniol Road, Bangor, Gwynedd

Principal Excavations

(1) Capel Eithin, Gaerwen, Anglesey. A second and final season of excavations revealed an early Christian cemetery. Further features of Neolithic and Bronze Age date were also discovered.

(2) Cathedral Church in Bangor. Trial excavations adjacent to this site showed the presence of an early cemetery.

(3) Roman Fort at Caer Gai, Meirionnydd. A section through the defences, established the sequence of defences.

Surveys and other work

(5) An archaeological survey at Ardudwy, Meirionnydd was prepared and published in the Journal of the Meirionnydd Historical and Record Society.

(6) In conjunction with the University of Keele, a palynological study was made of the peat bog adjacent to the Iron Age farmstead at Moel Y Gerddi, Meirionnydd.

(7) Planning control proceeded as routine, as did work on the Sites and Monuments Record.

ANCIENT MONUMENTS BOARD FOR WALES
30th ANNUAL REPORT: 1 JANUARY 1983—31 MARCH 1984

1. During the period of this Report, the Board met twice—once in Cardiff and on the other occasion with you at Gwydyr House, London. The Chairman also met you separately in London on behalf of the Board, to discuss proposed changes in the organisation of ancient monuments work.

Reorganisation of the Ancient Monuments Board for Wales

2. Towards the beginning of the period of this Report, you announced your decision to change the Board's method of operation, as part of wider measures aimed at improving the existing ancient monuments' organisation. You decided that the Board should no longer necessarily hold regular formal meetings but that it should operate on a "panel" system whereby advice could be sought and tendered quickly in writing as the occasion demanded. It was your intention that this should enhance the role of the Board by involving us in major policy initiatives as and when they arose rather than the more routine matters which were hitherto deferred until our normal bi-annual meetings. As you know, the Board expressed reservations to you about the new arrangements. In particular, some members voiced concern that the absence of regular meetings would result in the loss of the exchange of information and views necessary to provide proper general and detailed advice. It was also felt by some members that without occasional visits to monuments by the full Board, an important aspect of our capability would be lost. However, we agreed to see how the new arrangements worked for a period before submitting our considered opinions. We hope to review the arrangements later in 1984 and to submit a detailed report to you.

Proposed Reorganisation of Ancient Monuments and Historic Buildings Work in Wales

3. As part of your review of existing organisation and procedures, you expressed a wish to improve the presentation of monuments in your care so that they could be better enjoyed and appreciated by the public. As a result, you commissioned a report by John Brown Tourism Marketing and Development Services to help gauge the existing defects and the scope for improvements. You subsequently decided that a new unit—"Cadw: Welsh Historic Monuments"—should be established to implement the presentational and marketing recommendations made by John Brown as well as to administer the more traditional conservation and related functions in the ancient monuments and historic buildings field currently undertaken within the Welsh Office. Unlike the new Commission established in England, "Cadw" would be non-statutory and, thus, you would continue to be statutorily responsible for the exercise of these functions.

4. We appreciate your wide consultation on this matter and, in particular, your wish to meet this Board to discuss the detailed proposals. Whilst we welcomed the intention to improve the presentational and marketing aspects

of Welsh monuments, we expressed certain reservations about the scope for a possible conflict of interests as between marketing on the one hand and conservation on the other. We sought assurances about the continued primary importance of conservation responsibilities and the undiminished level of finance necessary to support them. You kindly provided these assurances. You also told us that the Director of "Cadw" would be directly responsible to a Steering Group chaired by you and comprising of the Chairmen of the Wales Tourist Board, the Historic Buildings Council for Wales and the Ancient Monuments Board for Wales. This proposed arrangement has allayed some of our uncertainties. We are grateful too, for the way in which you have allowed the Chairman to be personally involved in some of the preparatory work, notably in the consideration of candidates for the post of Director of "Cadw". The Board welcomes the fact that you will maintain your statutory functions in this field and pledges its support in co-operating fully with the new unit. Similarly it will advise you at once if it considers that "Cadw" is not operating to best effect. We look forward to the challenges ahead in the operation of the new organisation.

INDIVIDUAL CASES

Castell Dinas Bran, Llangollen

(Cover illustration and Plate 3)

5. The first formal request for advice from the Board operating under the new "Panel System" concerned Castell Dinas Bran, Llangollen. We were asked whether or not you should take this particular monument into care.

6. In considering the question the Chairman visited the site, accompanied by another member of this Board, Mr. R. B. Heaton, and officials of your Department. Written comments were obtained from other Board members.

7. We agreed about the importance of this site and its suitability, in principle, for guardianship if it proved necessary. However, it was our considered opinion that such action did not appear to be necessary at present. In particular, we noted that the monument was in a good state of repair as a result of maintenance work carried out by your Department. We hoped that this arrangement would be repeated when necessary as a suitable alternative to taking the monument into guardianship. We recommended however, that the situation concerning public access and the structural condition of the monument be carefully monitored, and, in the event of any serious change taking place we would wish to be informed so that we could reconsider the issue if necessary.

8. Your subsequent acceptance of these recommendations was noted by the Board.

Tŷ Mawr, Castell Caereinion, Powys

9. The consultation process involving local and national conservationist interests proved both lengthy and detailed. However, it has resulted in a number of options for us to consider. In particular, interest has been shown by

the Landmark Trust in acquiring the building for complete restoration on its present site for future use as holiday accommodation. We will be considering all the options and submitting our recommendations to you soon.

Bulmore, Caerleon—Developments

10. The Board was concerned to learn of development at this site which had resulted in the unearthing of Roman remains in an unscheduled area. We were pleased, however, to learn that further areas of land at Bulmore had now been scheduled and accordingly afforded statutory protection from unauthorised development. We also recommended that further geophysical surveys should be carried out in the wider area to ascertain whether other sites in the vicinity should be afforded such statutory protection.

Aerial Photography (Plate 4)

11. We understand that, following consultations with officials of your Department about the possible funding of Aerial Photography in Wales, a trial programme is to be commenced in 1984/85. We trust that this will prove beneficial not only for the monitoring of existing Scheduled Ancient Monuments but also in the identification of new and important sites.

Trawscoed Roman Fort

12. As a result of representations about this site, the Chairman examined the protection afforded to this important Roman Fort, which is a scheduled ancient monument in Government ownership. The position is that the site, which is currently owned by the Department of the Environment is governed, for development purposes, by similar procedures to those followed on sites in private ownership—i.e. a form of Scheduled Monument Consent is required for any works there. Additionally, it is understood that the site is subject to a transfer of ownership to the Ministry of Agriculture Fisheries and Food, and that the Deeds of Transfer will impose restrictions which will afford further protection to the scheduled area.

Scheduling

13. The Board has noted the inclusion of 25 additional sites in the Schedule during the period of this Report. These are listed at Appendix 1.

Rescue Archaeology

14. The Rescue Schemes carried out by the Welsh Archaeological Trusts during the period of this Report are detailed in Appendix 2 to this Report.

APPENDIX No. 1

MONUMENTS ADDED TO THE SCHEDULE

DYFED

Pembroke (158-SM 976 017)
Monkton Priory Dovecote.

St. Davids (157-SM 766 257)
Standing Stone N.W. of Trecenny Farm.

Llanfynydd (146-SN 561 309)
Y Garn Ring Cairn.

Llanychaer (157-SN 017 342)
Iron Age enclosure in Kilkiffeth Wood.

Bayvil (145-SN 113 418)
Enclosure site 70 m North of Post-Coch Crossroads.

Llainwen (135-SN 691 922/690 924)
Group of 3 cairns on Llainwen moorland.

St. Davids (157-SM 717 236)
Lower Tregennis Burial Chamber, St. Davids.

Tenby (158-SN 131 011)
Old Market Cross, Tenby.

Pembroke (158-SM 988 012)
Additional parts of Medieval Town Wall, including a tower at Goose's Lane, Pembroke.

Crinow (158-SN 129 142)
Clynpattel motte and bailey.

Newton North (158-SN 089 141)
Iron Age Hillslope Enclosure in Canaston Wood.

Whitchurch (157-SM 802 239)
Promontory Fort S. of Solva Harbour.

Puncheston (145-SN 001 322)
Iron Age/Romano-British settlement and field system on Fagwyr—fran Moor.

GWYNEDD

Llandudno (116-SH 799 816)
A limestone cave at Ogof Tan-y-Bryn, Llandudno.

Aberdaron (123-SH 116 226/120 226)
Additional area including 3 rectangular long houses.

GWENT

Crucorney Fawr (161-SO 342 222)
Penbidwal Moated Site, near Abergavenny.

Kemeys Inferior (171-ST 360 916)
Great Bulmore Roman Site (extensions to scheduled area).

POWYS

Ystradgynlais Lower (159-SN 817 107)
A cairn of loose stones at Garn Coch—Mynydd y Drum Round Cairn.

MID GLAMORGAN

Merthyr Tydfil (160-SO 038 069)
Remains of Blast Furnace, Cyfarthfa Ironworks.

Tythegston (170-SS 851 835)
Remains of Blast Furnace and buildings, Cefn Cribwr Ironworks.

Merthyr Tydfil (171-SO 038 071)
Pont-y-cafnau Tramway Bridge.

SOUTH GLAMORGAN

Radyr (154-ST 134 800)
Cooking Mound East of Taff Terrace, Radyr.

WEST GLAMORGAN

Dyffryn Clydach (170-SS 737 978)
Neath Abbey Ironworks (extended area).

Blaengwrach (179-SN 865 050)
Remains of Venallt Ironworks.

CLWYD

Denbigh (116-SJ 053 659)
Denbigh Castle and Medieval Town—additional area.

APPENDIX No. 2

RESCUE ARCHAEOLOGY WORK CARRIED OUT IN WALES 1983

GLAMORGAN-GWENT ARCHAEOLOGICAL TRUST LTD.

Chairman: H. N. SAVORY, M.A., D.Phil., F.S.A.
Director: G. DOWDELL, B.A., Dip.G.S. (Harl.)
Headquarters: 6 Prospect Place, Swansea, West Glamorgan

Principal Excavations

(1) Loughor, West Glamorgan. Excavations on the site of the Roman Auxiliary Fort continued throughout 1983. A number of sites within and adjoining the defences of the Fort have been excavated. Work will continue into 1984.

(2) Cowbridge, South Glamorgan. Excavations at Bear Field have revealed intense Roman activity dating from the late 1st Century A.D. to the 4th Century A.D.

Surveys and other work

(3) Coelbren, West Glamorgan. An agricultural drainage trench caused damage to the defence ditches of the north side of the Roman Fort. A section of the causeway carrying the road to the north revealed some waterlogged brush wood, probably associated with the defences.

(4) Brynmill, Swansea. Limited investigation of 3 mill sites was undertaken at the request of Swansea City Council.

(5) Carmarthen Road, Swansea. Investigations during early clearance work at Dyfatty Lights indicated that kiln furniture, biscuit china and clay pipe fragments probably originated from the area of the Hafod.

(6) Brynmawr, Bryn-y-Gaer. An initial survey of this possible hill fort indicated the existence of a probable defence enclosure, albeit badly damaged by erosion and quarrying.

(7) Caerleon, Lodge Road. A watching brief was carried out during excavation work for foundations. A possible wall was noted in one trench and a collection of degraded (possibly redeposited) Roman pottery was recovered.

(8) Other smaller scale excavations, surveys, watching briefs and recording were carried out in response to imminent or reported damage to monuments and on request at the following areas:

Ewenny
Pwll yr hwyaid Farm, Kenfig
Neath Roman Fort
Abergavenny Castle
Caerleon
Marshfield
Tintern Abbey, and
Backingstone Farm, Bishopston

(9) Monitoring of planning applications before determination and liaison with local authorities on matters connected with development control has continued.

(10) Interim notes on Trust excavations have been published in relevant journals. A number of excavation reports are complete and await printing while work continues on all other completed excavations.

(11) Work continued on the compiling and updating of the Trust's Record with exchanges of information occurring on a regular basis with various institutions and organisations e.g. the Royal Commission on Ancient and Historical Monuments (Wales).

DYFED ARCHAEOLOGICAL TRUST LTD.

Chairman: Professor W. F. GRIMES, C.B.E., M.A., D.Litt., F.S.A., F.M.A.

Director: D. G. BENSON, Esq., M.A.

Headquarters: The Old Palace, Abergwili, Carmarthen, Dyfed

Principal Excavations

(1) Llanilar. Excavation of Bronze Age site prior to second phase housing development.

(2) Dan-y-Coed, Llawhaden. Completion of total excavation of Iron Age/Romano-British enclosure.

(3) Woodside, Llawhaden. Excavation of Iron Age outworks prior to levelling.

(4) Holgan Camp, Llawhaden. Clearance of Iron Age promontory fort and trial excavation.

(5) Dan-y-Coed, Llangynog. Total excavation of Iron Age enclosure prior to levelling and land improvement scheme.

(6) Llandovery. Excavation outside Roman Fort in advance of housing development.

(7) Carmarthen, Priory Street. Completion of excavation of area of Roman Town prior to redevelopment.

(8) Carmarthen Friary. Excavation of Medieval Greyfriars in advance of superstore development.

Surveys and other work

(9) Survey and small scale excavation on Cross Hands/Drefach/Llanddarog by-pass route.

(10) Survey of Carew Castle earthworks for Pembrokeshire Coast National Park.

(11) Commencement of survey of sites in Carmarthen District.

(12) Continued Sites and Monuments Records work.

(13) Continued development control liaison with Local Planning Authorities and local plan work.

(14) Establishment of Managing Agency for MSC schemes for all projects.

THE CLWYD-POWYS ARCHAEOLOGICAL TRUST

Chairman: H. Noel Jerman, Esq., C.B.E., M.A., F.S.A.
Director: C. R. Musson, Esq., B.Arch., M.I.F.A.
Headquarters: 7a Church Street, Welshpool, Powys

Principal Excavations

(1) Four Crosses, Llandysilio, Powys. Continued excavation of the complex of ring-ditches (Neolithic and Bronze Age burial mounds) and pit-alignments (as yet undated field system) in the Severn/Vyrnwy Valley, in response to plough-erosion.

(2) Naid y March, Brynford, Clwyd. Investigation of a scheduled pair of standing stones, in advance of road improvements.

(3) Dinorben hillfort, Abergele, Clwyd. Investigation of a possibly Roman or earlier boundary bank outside the defences of the hillfort, in advance of quarrying.

Surveys and other work

(4) Smaller-scale excavation or recording in both counties in response to imminent or reported damage to monuments, including relict landscape at Mynydd y Drum, Ystradgynlais, the site of a cremation burial at Fan y Big in the Brecon Beacons, an unusual and apparently pre-Norman moated enclosure at Cwrt Llechryd, Builth Road, and the Kerry cross-ridge dykes (all in Powys), and Llwyn Bryn-dinas hillfort and metalworking site at Llangedwyn in Clwyd.

(5) Continued work on publication and archive texts for earlier projects.

(6) Site visits in both counties, and the continued collection of aerial photographs of known and previously unrecorded sites in N. Powys/S. Clwyd.

(7) Continued work on the Sites and Monuments Records and development control procedures for both counties.

(8) Educational and publicity work through talks, lectures, site visits, newspaper articles and other publications.

GWYNEDD ARCHAEOLOGICAL TRUST LTD.

Chairman: Sir Idris Foster, F.S.A.
Director: R. B. White, Esq., B.A.
Headquarters: Deiniol Road, Bangor, Gwynedd

Principal Excavations

(1) Craeanog, Arfon. A mound of burnt stone was fully excavated in advance of gravel extraction. The site proved to be a "boiling mound" or "cooking place" of presumably Iron Age date.

(2) Plas Berw, Llanidan, Anglesey. A small scale excavation within and beyond the ruins of the medieval hall house produced evidence of a succession of drainage features and an expanse of rough paving.

Surveys and other work

(3) An archaeological survey of monuments of the Anafon Valley, Aber, was made following damage to monuments by the Welsh Water Authority.

(4) Observations were made on a number of Scheduled Monument Consent applications. Planning control continued as did work on Sites and Monuments Record.

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EMPLOYMENT PROTECTION (CONSOLIDATION) ACT 1978

LIMITS ON GUARANTEE PAYMENTS: A REPORT BY THE SECRETARY OF STATE FOR EMPLOYMENT

Required by section 148(5) of the Employment Protection (Consolidation) Act 1978 to be laid before Parliament

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Ordered by The House of Commons *to be printed*
2nd December 1985

LONDON
HER MAJESTY'S STATIONERY OFFICE
80p net

LIMITS ON GUARANTEE PAYMENTS: A REPORT BY THE SECRETARY OF STATE FOR EMPLOYMENT

1. This report is laid before Parliament in accordance with section 148 of the Employment Protection (Consolidation) Act 1978, reproduced in the Appendix, which requires me to carry out in each calendar year a review of certain limits contained in that Act. If I decide to vary any of the limits, I am required to lay before each House of Parliament a draft Order giving effect to my decision. If I consider that any of the limits should not be varied, I am required to prepare and lay before each House a report giving my reasons.

2. I have carried out the review for the calendar year 1985. I have decided that all but two of the limits should be varied and, simultaneously with this report, I am laying before each House a draft Order (entitled the Employment Protection (Variation of Limits) Order 1985) giving effect to my decision. The two limits that I have determined not to vary both relate to the guarantee payments provisions.

3. There are three limits to guarantee payments to be dealt with in the review under section 148. They are:—

(1) the amount of guarantee payment due to an employee in respect of any day, currently £10.50;

(2) the specified number of days in any relevant period for which the employer is required to make guarantee payments. The current limit is the number of days per week, not exceeding five, which an employee is required to work under his contract of employment; and

(3) the relevant period which is currently any period of three months.

4. In the light of the latest figures for increases in average earnings, and other factors, I have determined to increase the monetary limit of guarantee payment, and provision for this is included in the draft Order laid today.

5. I have taken the view that the other two limits should not be varied at this time. Both still seem to strike a fair balance between the employers' obligations and the employees' rights.

22nd November 1985.

Young of Graffham,
Secretary of State for Employment.

APPENDIX

EMPLOYMENT PROTECTION (CONSOLIDATION) ACT 1978

SECTION 148

148.—(1) The Secretary of State shall in each calendar year review—

(*a*) the limits referred to in section 15;

(*b*) the limit referred to in section 122(5); and

(*c*) the limits imposed by paragraph 8(1) of Schedule 14 on the amount of a week's pay for the purposes of those provisions;

and shall determine whether any of those limits should be varied.

(2) In making a review under this section the Secretary of State shall consider—

(*a*) the general level of earnings obtaining in Great Britain at the time of the review;

(*b*) the national economic situation as a whole; and

(*c*) such matters as he thinks relevant.

(3) If on a review under this section the Secretary of State determines that, having regard to the considerations mentioned in subsection (2), any of those limits should be varied, he shall prepare and lay before each House of Parliament the draft of an order giving effect to his decision.

(4) Where a draft of an order under this section is approved by resolution of each House of Parliament the Secretary of State shall make an order in the form of the draft.

(5) If, following the completion of an annual review under this section, the Secretary of State determines that any of the limits referred to in subsection (1) shall not be varied, he shall lay before each House of Parliament a report containing a statement of his reasons for that determination.

(6) The Secretary of State may at any time, in addition to the annual review provided for in subsection (1), conduct a further review of the limits mentioned in subsection (1), so as to determine whether any of those limits should be varied, and subsections (2) to (4) shall apply to such a review as if it were a review under subsection (1).

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HOUSE OF COMMONS

Tenth Report from the

COMMITTEE OF PUBLIC ACCOUNTS

Session 1985–86

The Urban Programme

Department of the Environment

Ordered by The House of Commons *to be printed*
20 January 1986

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31

The Committee of Public Accounts is appointed under Standing Order No 98, viz:

Committee of Public Accounts

98.(1) There shall be a select committee to be called the Committee of Public Accounts for the examination of the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit, to consist of not more than fifteen members, of whom four shall be a quorum. The committee shall have the power to send for persons, papers and records, to report from time to time, and to adjourn from place to place.

(2) Unless the House otherwise orders, each Member nominated to the committee shall continue to be a member of it for the remainder of the Parliament.

The cost of preparing for publication the Shorthand Minutes of Evidence taken before the Committee was £370.62.

The cost of printing and publishing this Report is estimated by Her Majesty's Stationery Office at £2,841.

THURSDAY 7 JULY 1983

The following were nominated as members of the Committee of Public Accounts:

Mr Dale Campbell-Savours
Mr Eric Cockeram
Mr Peter Hordern
Mr Michael Latham
Mr Robert Maclennan
Mr John Maxton
Mr Michael Morris
Mr Richard Needham
Mr William O'Brien
Mr George Park
Mr Nicholas Ridley
Sir Michael Shaw
Mr Barry Sheerman
Mr Robert Sheldon
Mr Michael Shersby

Mr Robert Sheldon was elected Chairman, 13 July 1983.

Subsequent changes in the membership of the Committee have been:

25 October 1983: Mr Richard Needham and Mr Nicholas Ridley discharged; Mr John Moore and Mr Fred Silvester appointed.

8 December 1983: Mr Barry Sheerman discharged; Mr Eric Deakins appointed.

1 February 1985: Mr John Maxton discharged; Dr John Marek appointed.

5 December 1985: Dr John Marek discharged; Mr Allan Rogers appointed.

The present composition of the Committee is:

Mr Robert Sheldon, Chairman

Mr Dale Campbell-Savours
Mr Eric Cockeram
Mr Eric Deakins
Sir Peter Hordern
Mr Michael Latham
Mr Robert Maclennan
Mr John Moore
Mr Michael Morris
Mr William O'Brien
Mr George Park
Mr Allan Rogers
Sir Michael Shaw
Mr Michael Shersby
Mr Fred Silvester

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TENTH REPORT

The Committee of Public Accounts has made further progress in the matter referred to it and has agreed to the following Report:

THE URBAN PROGRAMME

Introduction

C&AG's Report HC 513 of 1984-85 Paras 3, 2.1-2.10

1. The original, "Traditional", Urban Programme (UP) was developed by the Home Office in 1968 to supplement normal central and local government main programmes by providing additional grants for schemes to meet special social needs in urban areas. In 1978 the Government introduced the "Enhanced" UP, covering economic and environmental as well as social projects, and directed towards inner urban areas where the problems of deprivation were most severe. The underlying aims included the strengthening of the economies of the inner areas and the prospects of their residents; the improvement of the inner area environment; the alleviation of social problems; and the achievement of a new balance between the inner areas and the rest of the city region in terms of population and jobs.

2. The Enhanced UP was implemented through the Inner Urban Areas Act 1978 which enabled the Secretary of State for the Environment, who had assumed responsibility for urban affairs in 1976, to designate districts which included an inner urban area with special social needs and empowered local authorities for such designated districts to assist industry and commerce. Eligible expenditure incurred by local authorities would qualify for UP grants from the government under the Local Government Grants (Social Need) Act 1969. Accordingly eight (now seven) inner city "Partnerships" were established for the most deprived areas. In these, central and local government and health authorities were to develop jointly Inner Area Programmes (IAPs) for dealing with the problems and were to receive the largest proportion of UP funds. 15 "Programme Authorities" for districts with severe but less extensive problems were also established. These were also to draw up IAPs, though not in partnership with central government, and were to receive a smaller allocation of resources. By 1984–85 the number of Programme Authorities had increased to 23. The Secretary of State also designated a further 14 districts with less severe problems as Other Designated Districts (ODDs). These authorities would not be required to draw up IAPs but would receive UP allocations for economic development projects. By 1984–85 there were 16 ODDs. The "Traditional" UP, expanded to include economic and environmental projects, remains mainly to support projects in other urban areas.

C&AG's Report paras 3.1-3.3

3. For 1984–85 the UP in England was allocated £348 million set aside from five main expenditure programmes. Within this, about £48 million was for Urban Development Grants (UDGs) introduced in 1983–84 for private sector projects, £11 million for health authority projects and £289 million for the costs of local authority projects. The local authority projects were eligible for central government grants at the rate of 75 per cent of their direct revenue expenditure or loan charges, as appropriate. These resources were distributed between the categories of local authorities as follows: £129 million to Partnerships, £97 million to Programme Authorities, £8 million to ODDs, £44 million for Traditional UP and £70 million for other UP activities, mainly UDGs.

C&AG's Report paras 1, 1.2-1.3.2.11

4. We examined the arrangements for securing public accountability for the UP on the basis of a Report by the C&AG. This recorded the results of a review by the NAO which covered identification of the programme objectives, examination of the arrangements for achieving them and distribution of resources within the UP; examination of strategic plans for tackling the problems of urban deprivation; and examination of the arrangements for the appraisal and monitoring of the projects comprising the strategic programmes. The corresponding programmes in Scotland and Wales are administered by the appropriate Secretaries of State and were excluded from examinations as also were the Government's initiatives in Merseyside, highlighted in the House of Commons Environment Committee's Third Report of 1982–83 and certain newly introduced measures including the UDGs. In addition, as local authorities are not subject to audit by the C&AG, the NAO was unable to examine the management of the UP at that level.

(HC 18 of 1982-83)

Objectives of the UP

C&AG's Report paras 4.3-4.4, Appendix 5 Qs 291, 307

5. In 1981 Ministers stated the general objectives of their urban policy as improving employment prospects in the inner cities by increasing both job opportunities and the ability of disadvantaged residents to compete for them; reducing the amount of derelict land and buildings; strengthening the social fabric of the inner cities; and reducing the number of people in acute housing stress. Within this policy, the UP has a role in encouraging local authorities to develop a coordinated approach and action programmes to tackle the problems of their inner areas; to work with the private and voluntary sectors; to involve other agencies; to develop innovative solutions to their problems; and to identify and remove obstacles to the development of economic activity. None of the urban policy objectives, however, depends exclusively on the UP, and for some the Programme has a subsidiary role. Furthermore, the Department of the Environment (DoE) considered that setting precise and quantified national objectives for the UP, even where this could be done, would have no practical meaning for an individual local authority because the problems of deprivation varied in type, scale and intensity from authority to authority. However in the new UP Management Initiative (UPMI) introduced in May 1985, subsequently to the completion of the NAO investigation, DoE recognised the need for increasing precision in setting objectives.

Qs 291, 308, 311

6. Given the very broad terms in which the objectives of the Government's urban policy are expressed and the imprecise role of the UP in achieving these objectives, we recognise the difficulties for DoE in drawing up precise and quantified national objectives for the UP. We note that the resources allocated to the programme in its early years were modest and that they are still relatively small in relation to the total budgeted expenditure of Partnership and Programme Authorities. While this may explain the seeming lack of urgency in setting national objectives for the UP, it appears to us that without a greater degree of precision in setting such objectives it will not be possible to assess, on a national basis the effectiveness of the programme expenditure in achieving policy objectives. In our view, as a matter of general principle, public expenditure should be incurred only after clear and quantified statements of what

it is expected to achieve have been formulated. We recognise that as the UP is intended to meet local needs a significant degree of responsibility for the programme should lie with local authorities; but the degree of support by central government is unusually large and should be matched so far as possible by clear and quantified Government objectives for the programme. The UPM, if successful, will represent progress towards this but substantial resources have been allocated to the UP since at least 1978–79 and we consider that there has been undue delay in setting such objectives. We return below (paragraph 12) to the operational difficulties which flow from this deficiency.

Management of the UP

(a) *General*

&AG's eport paras 1, 4.8

7. Within central government public accountability for the UP rests principally with DoE since the UP is supported by a 75 per cent Government grant to local authorities, but responsibility for running the programme is divided. Much has been deliberately devolved to local authorities; in consultation with DoE, they draw up in IAPs the strategies for meeting local needs and, together with health authorities, they initiate and implement projects. They also consider bids and monitor projects put forward by other bodies, principally voluntary organisations. DoE issue guidelines on policy and guidance notes on the preparation of IAPs and the handling of projects. They also make expenditure allocations; process draft IAPs and projects for Ministerial approval; and assess and monitor the implementation of strategies and, on a selective basis, the

283 individual projects. The Department considered that, as local authorities were elected bodies with a 25 per cent stake in the UP and subject to external audit by auditors appointed by the Audit Commission, the initial responsibility for developing a clear and acceptable programme strategy lay with them. They saw DoE's responsibilities as ensuring that ministerial guidelines were observed, that propriety and regularity were achieved and that good value for money was secured.

&AG's eport paras 5, 4.8

8. In accordance with their responsibilities, in July 1981 DoE issued Partnership and Programme Authorities with Ministerial Guidelines explaining the Government's objectives and setting out the priorities for the UP. These indicated that the main thrust of IAPs should be towards projects designed to stimulate economic activity and improvement of the physical environment thus helping to attract private investment. Some priority needed to be given to improvement of facilities and services for the disadvantaged including minorities such as ethnic groups. Expenditure on capital account was to be substantially higher than on revenue and projects suitable for main programmes were only to be included in exceptional circumstances. The Guidelines also specified the arrangements for local authorities to secure approval for UP projects. These called for authorities to include in draft IAPs, submitted annually for a period three years ahead, brief details of each project intended for implementing the UP strategy. Once IAPs were approved by Ministers the local authorities would not need to seek DoE approval for the individual projects unless DoE asked for fuller details.

C&AG's Report paras 4.8 and 4.11

9. In addition to these Guidelines, in 1982 and 1983 DoE issue Authorities with detailed guidance concerning the preparation of IAP and the appraisal of certain types of projects included in them. To som extent this guidance has been overtaken by the new arrangement introduced by the UPM to which we referred briefly in paragraph 5.

(b) *Designation of Authorities*

C&AG's Report paras 3.4 and 3.5 Q 290

10. The C&AG's Report confirmed that the designation of loca authorities for UP purposes was based upon statistical analysis of censu data to arrive at eight indicators of urban deprivation. This enabled Do to rank authorities according to the intensity of deprivation but succes sive administrations had found it necessary to take into account othe factors, such as the general economic structure of the area, the othe resources available to the authority and other conditions not reflected i census information, in finalising the category into which authoritie should fall. It is clearly right, particularly as judgments are involved in th process, that the classifications of local authorities, and thus their share of UP funds, should not become permanent and we therefore welcom the assurance of reviews by DoE and changes made when circumstance indicate it.

(c) *Local strategy*

C&AG's Report paras 5.1-5.9

11. The C&AG's Report indicated that notwithstanding Do pressure, following a 1983 survey which had revealed widespread defec in the content and quality of IAPs, the majority of local authorities sti failed to adhere closely to DoE guidance on the preparation of thes programmes, particularly as regards rationalisation of the strategy fo

Q 283

dealing with their problems. DoE told us that the problem was one of lack of systematic documentation but they had recognised the need for more systematic approach to the production of IAPs. They had accor ingly developed the UPM. In relation to IAPs the UPM called for a clea statement of objectives and priorities related to the needs of the area an consistent with the Ministerial policy objectives for the UP as a whol with the list of proposed projects explicitly related to these prioritie DoE had discussed the UPM with the local authority associations and had replaced the 1981 guidelines.

12. In view of the degree of responsibility delegated to local autho ties for management of the UP (paragraph 6 above), we must expre concern at DoE's delay in issuing adequate guidance as regards formul tion and management of local strategies. Guidance on the preparation IAPs was not issued until 1982, at least four years after introduction of th Enhanced UP, and widespread non-compliance has already made necessary to reinforce its provisions through the 1985 UPM. We ha already drawn attention to some of the problems flowing from the lack quantified national objectives for the UP. A further problem is that the lack places additional difficulties in the path of local authorities in dra ing up strategies which will conform to government urban policies an meet the objectives effectively. The same difficulties will meet DoE their examination and evaluation of these strategies and the proble will be compounded when the strategic planning documentation is not

to standard. We trust that the UPM will result in fully satisfactory plans and shall return to the matter in due course.

(d) *The Appraisal of Projects*

C&AG's Report paras 5.10-5.11

13. It is necessary to appraise projects proposed for inclusion in IAPs to ensure that they comply with Ministerial objectives and are likely to be effective both in implementing local strategy and in achieving objectives efficiently and economically. In accordance with the arrangements outlined in paragraph 7 for the division of responsibility between DoE and local authorities, DoE regard local authorities as primarily responsible for appraising the projects put forward in draft IAPs. To assist local authorities in carrying out these appraisals DoE have issued guidance notes, referred to in paragraph 9, on the general principles which should underlie the selection and appraisal of certain types of economic projects. DoE do not generally seek to subject projects to further departmental appraisal though they scrutinise information provided by local authorities about individual projects to ensure that they comply with ministerial objectives and to identify those meriting more detailed scrutiny under management by exception arrangements.

C&AG's Report paras 4.11-4.14

C&AG's Report paras 5.14, 5.16, 5.18

14. The C&AG drew attention to the limited scope of DoE's guidance on project appraisal: it covered only certain types of "economic" projects which accounted for about 25 per cent of expenditure. There was no guidance concerning the remaining "economic" projects or environmental and social projects nor was there detailed guidance on how the principles should be applied in practice. The C&AG also indicated that DoE had not drawn conclusions from the cases selected for more detailed scrutiny under the management by exception arrangements regarding the adequacy of appraisal work by the local authorities and that a 1983 general investigation of local authority appraisal practices had been confined to industrial and commercial projects involving assistance to private sector firms.

C&AG's Report paras 5.22-5.23, Q 283

15. DoE indicated that their arrangements reflected the general policy of the Government for reducing detailed supervision of local authority projects and for introducing measures to improve local authority accountability and value for money. However, under the UPM introduced in 1985, they were seeking to improve the appraisal of individual UP projects through improved access to basic descriptive and financial information about projects, identification of specified targets related to local priorities and, wherever possible, the identification of quantified output targets. In this connection they had agreed with the local authorities 53 standard output measures and that in future each project would incorporate at least one of them.

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16. It is clearly of the utmost importance that the projects through which a programme is implemented should be subject to careful appraisal to ensure that they are well adapted both to achieve the programme objectives effectively and to deliver value for money. Given the fact that the UP includes some 12,000 current schemes, many of which are small, it is clear to us that the main responsibility for appraisal of proposed projects should lie with local authorities, backed up by selective DoE

appraisal of proposals exhibiting unusual features or of special interest We must therefore express concern that DoE's guidance to local authori ties regarding appraisal of proposed projects is still not comprehensive and that they are not yet in a position adequately to assess the perform ance of local authorities in project appraisal, whether under the manage ment by exception arrangements or otherwise. We note moreover that i is only from 1985 that DoE have agreed a comprehensive list of outpu measures for use in assessing the success or otherwise of projects i achieving their objectives. We can only express regret that the enhance UP should have run for seven years before agreement on these measure should have been secured. In this connection we appreciate that it may b some further time before the results of projects incorporating the nev measures become available to throw light, not only on the achievement of local authorities in carrying out UP projects, but also regarding th adequacy of their project appraisal arrangements.

(e) *Monitoring*

C&AG's Report Part 6

17. The C&AG drew attention to two aspects concerning the monito ing of the progress of the UP. His Report referred first to the arrange ments for checking the progress of programme expenditure again allocations and the success of projects in achieving the results expected them at the appraisal stage. It also referred to the need to measure tha the programme as a whole achieved its objectives.

C&AG's Report paras 6.1-6.10

18. Responsibility for the monitoring of projects is shared betwee DoE and the local authorities. DoE have encouraged and assisted loc authorities to develop their own monitoring systems and have issue guidance on monitoring industrial and commercial projects involvin financial assistance to private sector firms. This guidance supplemen the guidance concerning appraisal of these projects (paragraph 14). Do themselves were primarily concerned with checking the progress expenditure and ensuring that, in aggregate, it did not exceed the tot allocation. The work did not extend to examining, on a systematic basi that projects were implemented economically and efficiently. Neverth less, in response to the Treasury's concern that some form of controlle monitoring should form part of the management by exception arrang ments referred to in paragraph 13, DoE introduced arrangements fro January 1983 under which they check on an annual basis a 10 per ce sample of implemented cases to establish that public money is use prudently and that planned benefits are being achieved.

C&AG's Report paras 6.11-6.17

19. The first round of the 1983 arrangements, referred to as "Guidelines monitoring exercise" comprised a sample of 114 projec which DoE assessed against criteria agreed by the Treasury includi whether projects were recognisably doing what they set out to do a were using resources efficiently and cost-effectively. The exercise in cated that a substantial majority of projects were judged to be successf in those terms though the C&AG pointed out that the analysis w subjective because the objectives of many projects had not been quan fied or described qualitatively in sufficient detail.

C&AG's Report paras 6.18-6.24

20. In addition to the Guidelines monitoring exercise DoE have esta lished an Inner Cities Monitoring Group to coordinate monitori

activities in relation to inner city policy. The Group's reports confirm the weaknesses in DoE monitoring arrangements we mention in paragraph 19 and point also to deficiencies in the arrangements used by Partnerships and Programme Authorities to monitor both strategic programmes and individual projects.

Qs 283, 287-8, 310-2

21. DoE told us that the UP was quite small to begin with. Over recent years there had been a steady growth in the measurement of project achievements and now, with the introduction of the UPM, arrangements for systematic assessment of strategies and projects had been put in place. In addition to incorporating at least one of the 53 agreed output measures in the original project proposals, the UPM requires local authorities to monitor each project at least once during its life. While the vast majority

Q 289

of the 12,000 schemes running at any time were relatively small and few ran for any length of time, there were a number of large schemes at which DoE would expect the local authority to look very closely.

22. While we accept DoE's assertion regarding the slow growth of UP expenditure in the programme's early years, we note that expenditure reached £93 million in 1978–79 and from then rose steadily to its 1983–84 and 1984–85 levels of £348 million. While a relatively relaxed approach to the monitoring of projects might be justified while the resources allocated to a programme are restricted, once material sums are made available there is a clear need for appropriate monitoring to begin immediately. We can only express regret that DoE did not recognise the need for systematic monitoring of project achievements to start in 1978, when the Enhanced UP was introduced, rather than in 1985 when the UPM started, particularly as it appears that full benefit from the new

Q 292

arrangements will only be available at the end of 1986–87—almost 10 years after UP expenditure took off from the low levels of the former scheme. This example underlines the importance of demonstrating that public expenditure achieves the results intended and the need for all expenditure programmes to include appropriate monitoring systems from the outset.

C&AG's Report paras 6.25-6.30

23. The C&AG drew attention to the possibility that the monitoring of local strategies and projects might be supplemented by a review of the achievements of the UP as a whole in reducing the levels of urban deprivation. DoE had not in fact undertaken such a review partly because they did not have the information reflecting the benefits arising from the expansion of the UP in the late 1970s. In addition they pointed to the difficulty of excluding the effect of forces external to the UP which is

Q 291

typically less than five per cent of the total budget of a Partnership or Programme Authority. Because of this it was very difficult to pick out the contribution made by the UP except by examining the effect on neighbourhoods. Consequently they had concentrated on the measurement of outputs from schemes and had commissioned research evaluation projects which had proved of considerable benefit.

24. Notwithstanding these difficulties and shortcomings in monitoring, it seemed to us that the accumulated experience of operating the UP should have generated information useful for the programme's future

Qs 308-9, 318 development. We therefore endorse DoE's recognition of the need t assist development of the programme by identifying and disseminatin examples of good practice and successful projects. We are pleased to not that in examining project proposals, they already give preference t schemes which in their experience are more likely to be successful. In th
Qs 285-7, 291 connection DoE provided us with a considerable volume of informatio concerning the achievements of individual local authorities and their U projects. We found difficulty in evaluating the significance of this info mation. For instance, a great deal of it related not to final outputs, whos measurement is clearly not easy, but to intermediate outputs, and Do did not explain what these intermediate achievements meant in terms value for money. Similarly, while the results of the numerous extern evaluation studies commissioned by DoE appeared to indicate that pr jects had been successful in improving conditions in inner city neighbou hoods, we received less information concerning the suitability of loc authority strategies for reversing the trends of urban deprivation in the areas in an effective and economical manner.

(f) *Coordination of projects*

Q 294 25. DoE confirmed that, in addition to the UP, substantial sums money flow from other programmes towards the inner cities. Th instanced estimated expenditure in 1985–86 in the Partnership areas £100 million by the Manpower Services Commission, £35 million by D on innovative and small-firms schemes and £12 million by the Hon
Qs 326-7 Office on support for ethnic minority schemes. DoE told us that the Ci Action Teams had brought together the departments involved in inn city matters in order to develop better coordination in the Partnersh areas and to secure better programme outputs in the city areas. The were very close working arrangements in the regions and they were ve
Qs 323-4 conscious of the possibility of multiple applications for project finance of authorities seeking UP aid for projects appropriate to ma programmes. With regard to the latter DoE told us that this had alwa been a matter for concern: many of the UP schemes rejected at the dr IAP stage had failed because they were considered to be appropriate main programmes. The first Guidelines monitoring exercise had in fa uncovered only one scheme which should have been funded under ma programmes. Finance for it had been discontinued. However U schemes had an innovative aspect and about 47 per cent of those whi ran their full time in the UP were later absorbed by main programme

26. We note the arrangements which have been devised to ensure th projects do not secure multiple allocations from programme resource This is clearly not an easy matter particularly when the evidence indicat quite clearly that, once an innovative aspect has expired, many proje are appropriate to and are accepted into main programmes (and th presumably attract a smaller degree of central Government funding). W trust that the Ministerial review of urban policy currently in progress w bear in mind the need for precision in defining the scope of programm so as to avoid overlap between them as well as unjustifiable inclusion mainstream schemes in the UP.

General

27. We do not find it easy to reach a conclusion about the UP. Clearly our inner city areas need help in overcoming their problems but the information we have received does not convince us that the UP yet represents a well designed policy instrument based on a clear understanding of the problems and what needs to be done to solve them. We acknowledge the inescapable difficulties created by the shared responsibilities of central and local government and the problems of reconciling national and local objectives. But the need for clear objectives is intensified when the programme is implemented through a host of small, short-term, projects. This is because there are problems not only in ensuring that such projects have coherent strategic purposes and are targeted towards an objective in an efficient and economical manner but also in measuring achievements, particularly when it is difficult to disentangle the UP from the effects of other closely-related programmes. We recognise in the UPM a determined, if belated, effort to put the management of the UP on a firmer footing and we propose to re-examine the programme in due course to appraise its results. In the meantime we trust that work both to clarify policy objectives and to measure the success of the UP in reversing trends in urban deprivation will continue.

Summary of Main Conclusions and Recommendations

28. With regard to the objectives of the UP

(i) We consider as a matter of general principle that public expenditure should be incurred only after clear and quantified statements of what it is expected to achieve have been formulated (paragraph 6).

(ii) We recognise that as the UP is intended to meet local needs a significant degree of responsibility for it should lie with local authorities; but the degree of support by central government also requires, so far as possible, clear and quantified Government objectives for the programme; we consider that there has been undue delay in setting these (paragraph 6).

With regard to the management of the UP

(iii) We welcome the evidence that the classifications of local authorities, and thus their share of UP funds, can be changed when circumstances indicate it (paragraph 10).

(iv) In view of the degree of management responsibility delegated to local authorities we must express concern at the delay in issuing adequate guidance as regards formulation and management of local strategies (paragraph 12), the appraisal of proposed projects (paragraph 16) and the monitoring of project achievements (paragraph 22).

(v) This case underlines the importance of demonstrating that public expenditure achieves the results intended and the need for all expenditure programmes to include appropriate monitoring from the outset (paragraph 22).

(vi) We endorse DoE's recognition of the need to assist development of the programme by identifying and disseminating examples of good practice and successful projects (paragraph 24).

(vii) We trust that the current Ministerial review of urban policy will bear in mind the need for precision in defining the scope of programmes to avoid overlap between them as well as unjustifiable inclusion of mainstream schemes in the UP (paragraph 26).

General

(viii) We are not convinced that the UP yet represents a well designed policy instrument based on a clear understanding of the problems and what needs to be done to solve them. But we recognise in the UPM a determined, if belated, effort to put management of the UP on a firmer footing, and propose to re-examine the programme in due course (paragraph 27).

(ix) We trust that work to clarify policy objectives and to measure the overall achievements of the UP in reversing the trends of urban deprivation will continue (paragraph 27).

GLOSSARY OF ABBREVIATIONS

C&AG	Comptroller and Auditor General
DoE	Department of the Environment
IAP	Inner Area Programme
NAO	National Audit Office
ODD	Other Designated District
UDG	Urban Development Grant
UP	Urban Programme
UPM	Urban Programme Management Initiative

PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT

MONDAY, 25 NOVEMBER, 1985

Members present:

Mr Robert Sheldon, in the Chair:

Mr Dale Campbell-Savours
Mr Eric Deakins
Mr Michael Latham
Mr Michael Morris
Mr William O'Brien
Sir Michael Shaw
Mr Fred Silvester

SIR GORDON DOWNEY, KCB, was further examined.

The Committee deliberated.

MR R JONES, Assistant Secretary, HM Treasury, was called in and examined.

The Comptroller and Auditor General's report on the Department of the Environment urban programme was considered.

MR T M HEISER, CB, Permanent Secretary, and Mr K E C Sorensen, Under Secretary, Inner Cities Directorate, Department of the Environment, were called in and examined.

[Adjourned till Wednesday at a quarter past Four o'clock.

* * * *

MONDAY, 20 JANUARY, 1986

Members present:

Mr Robert Sheldon, in the Chair:

Mr Dale Campbell-Savours
Mr Eric Cockeram
Mr Eric Deakins
Mr Michael Latham
Mr Robert Maclennan
Mr Michael Morris
Mr William O'Brien
Mr Allan Rogers
Sir Michael Shaw

SIR GORDON DOWNEY, KCB, was further examined.

The Committee deliberated.

Draft Report (The Urban Programme), proposed by the Chairman, brought up and read.

Ordered, That the Draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 28 read and agreed to.

Resolved, That the Report be the Tenth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order Number 92 (Select committees (reports)) be applied to the Report.

A paper was ordered to be appended to the Minutes of Evidence.

Ordered, That the Appendix to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman.*)

* * * *

[Adjourned till Wednesday at a quarter past Four o'clock.

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Monday, 25 November, 1985

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DEPARTMENT OF THE ENVIRONMENT
Mr T M Heiser, CB, and Mr K E C Sorensen 1

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MINUTES OF EVIDENCE TAKEN BEFORE THE COMMITTEE OF PUBLIC ACCOUNTS

MONDAY, 25 NOVEMBER, 1985

Members present:

Mr R Sheldon, in the Chair

Mr D Campbell-Savours
Mr E Deakins
Mr M Latham
Mr M Morris
Mr W O'Brien
Sir Michael Shaw
Mr F Silvester

Sir Gordon Downey, KCB, Comptroller and Auditor General, called in and further examined.

Report by the Comptroller and Auditor General

DEPARTMENT OF THE ENVIRONMENT: URBAN PROGRAMME

Examination of witnesses

Mr T M Heiser, CB, Permanent Secretary and Mr K E C Sorensen, Under-Secretary, Inner Cities Directorate, Department of the Environment, called in and examined.

Mr R Jones Assistant Secretary HM Treasury, called in and examined.

Chairman

283. Welcome to the Committee. We are today considering the C&AG's report on aspects of the Urban Programme. I want to start by putting a number of questions relating to the part that is played by local authorities in this programme and then I will move on to the work of your Department. Paragraph 6 of the C&AG's report on page 2 tells us that a large part of the responsibility for running the Urban Programme has been placed upon local authorities. What are you doing to ensure that all local authorities develop a clear and acceptable strategy for meeting the objectives thus set out.

*(*Mr *Heiser)* Could I begin my answer by saying where we stand in relation to local authorities. They are elected bodies, they have a 25 per cent stake in the Urban Programme through their contribution to the schemes and they are subject to external audit by auditors appointed by the Audit Commision. So we take the view that the initial responsibility lies with them but we do of course recognise that we have a very important responsibility for our 75 per cent share of the grant in making sure that we discharge our responsibility for seeing that ministerial guidelines are observed, that propriety and regularity are observed as far as we are concerned and that we secure good value for money. The C&AG's report identified a lack of systematic documentation in the past on some of the things we have been doing. We recognise this and indeed we first perceived it in the review we carried out in 1983 of what was happening in relation to the guidelines. We have developed what we now call the Urban Programme Management Initiative (UPM). When the Comptroller and Auditor General was carrying out this investigation we were in the process of developing the UPM. We have dicussed it with the local authority associations and it is now in place. It is outlined in Appendix 5 of the NAO report. What we are now looking for is a systematic approach to the production of the inner area programmes which should contain a good strategy. This should start with the ministerial guidelines which are set out in the first paragraph of Appendix 5 and that provides a general framework of policy. We expect the local authority to make a local assessment of its needs and then to produce Urban Programme objectives in local terms. The next step is to see that the projects which the local authority brings forward are related to these objectives and that their effect is aggregated. For this it is important that we get good intermediate and final output measures. This is a difficult area on which you may wish to question me later but we are pleased that the local authority associations have agreed

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[Chairman *Contd.*]

with us upon identifying 53 output measures. The local authority will have to ensure that each project has at least one output measure, that it aggregates those output measures retrospectively in its IAP, and that it monitors each project at least once in its life. With this general approach we think we will get a systematic approach to the urban programme across the board with all authorities. This is not to say that we have not done this in the past but we do accept that we need to get more systematic documentation of what we have been doing. What I also would say is that we are moving up the learning curve on the measurement of outputs of Urban Programme projects and we attach very great importance to taking that work forward.

284. So what you are saying is that you hope to be able to assess the extent to which new projects are going to meet the objectives that are laid out even though you have not been able to do this wholly in the past. If we look at paragraphs 13 and 14 of the report they confirm what you are saying, that in the past the project appraisal has not been wholly effective and that you are making some improvements. How long do you expect these improvements to take to work through and what do you expect them to achieve?

*(*Mr *Heiser)* We think they are already working through. Would the Committee like me to say something about what we think has happened so far?

285. Yes, please.

*(*Mr *Heiser)* For example, we did look at outputs between 1979 and 1984 for about £250 million of schemes where the work on outputs had been taken some way forward—mostly intermediate outputs. The committee might find some of these figures interesting: in that year there were 3,000 factory units and workshops approved, and 4,000 grants to firms; and we estimate that between 36,000 and 41,000 jobs were created or preserved at an estimated cost in UP terms of £58 million. There were 200 training schemes financed by the Urban Programme; these have a throughput of about 7,000 trainees a year and the capital cost was about £8 million. On environmental schemes: something like 15,000 buildings were improved and cleaned at £27 million and 3,000 derelict sites at £50 million; and so on.

286. Are these what you call final output measures?

*(*Mr *Heiser)* No.

287. I am not quite sure of the distinction between intermediate objectives and final output.

*(*Mr *Heiser)* An intermediate output is one where, for instance, if you have a derelict site you might create a factory or workshop upon it and you have one workshop; it might have provision for half a dozen small firms to work in it. That is in the nature of intermediate outputs. A final output might be how many of those businesses are permanent. The final output is very difficult to measure. We have mounted no less than 20 research projects since 1979, seven of these were evaluation projects and some of them were focused on this very difficult area of trying to see what had happened. In one research project—and these are external research projects, not done by the Department—we found 14 local authority areas were investigated, 504 firms were questioned, 148 projects were looked at and we discovered that 84 per cent of the jobs that had been created by these projects went to inner city residents, which is a very important factor in the programme. We carried out an evaluation of environmental projects and we found that of the residents near areas where parks or open spaces had been created by the Urban Programme nearly 70 per cent thought that their neighbourhood was a better place to live and about 50 per cent reported they made much increased use of these spaces. There was an evaluation project by Birmingham called their five-year review. They found that 50 per cent of the residents in their inner core areas thought the decline of their areas had been arrested and 40 per cent thought they were better places to live. Some of these measures are in the nature of proxies for outputs but they do go very close to people living and working in the areas and this did seem to us to be something worth knowing when one tries to judge what has been happening with the Urban Programme. That is the sort of thing we have been looking at in the last years and we have more evaluation projects which have come along and which should show us more. The picture I am trying to draw is really one of evolution; we now hope with the Urban Programme Management initiative to do this sort of thing systematically across the board. I did not want to leave the

[Chairman *Contd.*]

impression that nothing had been happening: there has been a steady growth in measurement over recent years.

288. I am still not clear just how far monitoring is proceeding at the present time. In paragraph 16 we see that the extent of your guidance regarding monitoring at local level has been somewhat limited. If there is no monitoring in all these areas—perhaps you can tell me that monitoring is now satisfactory but if it is not—are you sure that the authorities have nevertheless developed satisfactory arrangements and are you able to see the results of this?

*(*Mr *Heiser)* Under the Urban Programme Management initiative we now expect local authorities to monitor in depth each project at least once in its life; so that will be a requirement placed on local authorities. At the moment we are carrying out our second guidelines monitoring. The Comptroller and Auditor General commented on our first monitoring project in 1983 that it was subjective: we always saw it as a pilot scheme. We are now beginning a second much more rigorous monitoring of the guidelines. We completed a pilot survey. We are beginning the full monitoring exercise and it should be finished by December. We are visiting a five per cent sample of projects, including projects that were looked at in the first guidelines monitoring exercise. So we ourselves hope to have early next year results of a fairly intensive, much more rigorous and objective guidelines monitoring exercise than the one we have carried out before. We would also expect to repeat that process from time to time.

289. You say you expect to look at these projects at least once in their lifetime but of course some of these lifetimes can be very lengthy indeed.

*(*Mr *Heiser)* Very few. Some of course will be but one of the interesting characteristics of the Urban Programme is that many of the schemes are small. We have no less than 12,000 schemes now running. Since we started in 1979–80 we have had 26,300 schemes submitted to us, we have approved 18,600, we have rejected 7,700 schemes for various reasons, we now have a running total of 12,000 schemes. Only 20 per cent of the capital schemes and 5 per cent of the current schemes cost more than £50,000. So the vast majority are relatively small schemes. The current schemes can be run for several years and there could be just a low level of support; but there are very few schemes which run for any length of time. There will be some, and we would expect the local authority to look very closely at the larger schemes and indeed we would ask questions about such schemes as time went on.

290. Perhaps I could turn now to the objectives of the Urban Programme, what it is you are trying to achieve. Paragraph 10 of the report tells us that the classification of the Urban Programme Authorities depends partly on the degree of urban deprivation and urban deprivation is measured by means of certain formulae, as far as I can see, and partly on perhaps less quantifiable factors. How do you achieve a consistency as between authorities in making allocations? I understand there can be nothing perfect in this but many of us know certain of these local authorities and wonder why one is in and another is out. Nevertheless I understand that particular problem and that is something you are always going to have. How do you attempt to achieve some objective consistency here?

*(*Mr *Heiser)* This goes back to the previous administration in 1978 when partnerships were first set up. The selection takes place against a background of census data. There are eight indicators listed in Appendix 3: such things as percentage of unemployment, percentage of lone parent families, pensioners and so on. We then take those indicators and the first step is to rank local authorities in the number of times they appear in the top ten or the top 50 of each indicator. That gives us some idea of the extent of deprivation as measured by these statistics. The second step is one in which we take the first six indicators where information exists at the census enumeration district level—quite a small area—and we rank authorities for each indicator according to whether they come above or below the norm. Then we add them together by a statistical technique, with which I am sure the Committee are familiar, called a Z score, which is just a way of bringing them all together in one number. So we get a ranking showing the intensity of deprivation by reference to these six indicators. I do not think any ready reckoner exists anywhere—in America or anywhere else—which can reduce these sorts of problems to one single figure. Successive administrations have found it necessary to use other judgments before they finalise the lists. As the C&AG noted in his

[Chairman *Contd.*]
report, Ministers take into account various factors such as the general economic picture, the resources that might otherwise be available to the authority and those sorts of conditions which do not manifest themselves in the census. I could give you an illustration of this. Hackney and Lambeth have very high Z scores: they have poor housing on these scores, concentrations of ethnic minorities and a good deal of social stress in terms of pensioners living alone and so on. Newcastle and Gateshead do not have Z scores that are very high, but they do have very large areas of dereliction and they have structural unemployment due to the decline of a manufacturing base. This brought them into the partnerships and they have stayed there. This is the kind of qualitative judgment which Ministers seek to make when they look at the background of statistical analysis. The last review of the authorities we chose was in 1983 and Appendix 1 shows that eight authorities were added to the programme authorities and three added to the list of other designated districts. That is the approach that is used: the statistical analysis to provide a background, a qualitative judgment on other factors which Ministers think relevant.

291. Paragraph 4.3 on page 11 says that the achievement of the Government's Urban Policy objectives does not depend exclusively on the Urban Programme and we understand that. In the next paragraph, paragraph 4.4, we see that you have up to this year considered it impractical to set exact and quantified objectives for the Urban Programme. If you have had no programme objectives, how are you able to measure progress towards achievement and to show yourselves and this Committee that the expenditure represents good value for money?

*(*Mr *Heiser)* I have touched upon some of the ways. We think that measurement of outputs for schemes is helpful; we think our research evaluation projects are of considerable benefit. Might I refer to the sorts of things which emerge from others who are involved in this process. The Association of British Chambers of Commerce carried out a review in 1985 and they found the urban block programmes represented excellent value for money and they quoted many Chambers of Commerce who found the same thing. If you look at various studies which have been done on certain neighbourhoods such as the Jewellery quarter in Birmingham which has been revived with the help of the Urban Programme, business has been brought back into the area, new jobs have been created, £1 million of urban grant was paid and £3¼ million of private sector investment was generated. Similar stories occur in the Lace Market in Nottingham which has been revived; Albert Docks in Liverpool is another case where £6 million of Urban Programme have produced a maritime museum and the numbers visiting have risen from 60,000 in 1980–81 to something like 250,000 so far this year. We have a good deal of evidence of that sort and if you look at the neighbourhood level, at the area level, you can see that a very substantial impact has been made on the neighbourhoods. What has to be remembered about the Urban Programme is that it is relatively small; it is worth putting it into perspective. A city has private and public expenditure going in. Merseyside, for instance, had no less than £1 billion of government expenditure estimated for 1984–85 where the Urban Programme money was only a small part, about £30 million. Local authority total budgeted expenditure for the partnership and programme authorities in 1984–85 was £3.5 billion; Urban Programme resources directed at those authorities was about £170 million. The quantities are quite small and it is therefore very difficult to pick out in an absolute sense the contribution the Urban Programme makes unless one moves down to neighbourhoods and areas to try to see what is happening there.

292. This obviously presents us with a problem because there is a general difficulty of measuring the effectiveness of the Urban Programme in isolation from the effects of other expenditures. Nevertheless if you are going to spend this money you want to be in a position to know what you are getting for it and that is why this Committee make a very big thing of discussing matters such as monitoring because we want to make sure both that the Department know how important it is to compare achievement with objective at what cost and that we are convinced ourselves. So we shall be pressing you again on these matters. How far do you think you will be able to convince the Committee on this if you were to come back again next year?

*(*Mr *Heiser)* The Urban Programme Management initiative actually applies to 1986–87. If we came back next year what we would find is that we could report by next

[Chairman *Contd.*]

autumn on the quality of the strategies which have been advanced. We probably could report upon our appraisal of schemes which we are developing through next year. We could also report upon our second guidelines monitoring exercise which is finishing in December. We could make a progress report of some interest within a year; to see the full benefit of the UPM would probably follow in the next year because it would be after 1986–87 is completed.

293. Do you think you will be able to satisfy us on the level of monitoring?

*(*Mr *Heiser)* I am confident that we will. There is a concern in my mind about trying to strike a proper balance between satisfying the Department, the Secretary of State and the PAC about the use of the money and not clogging up the system with an overheavy bureaucracy. There is always this balance to be struck; Government has tried to disengage from unnecessary intervention, unnecessary form-filling, but we think we have probably got the balance right and it has been a great satisfaction that the local authority associations have been able to agree with us upon the new measures we are taking because they do impose upon local government the collection of a substantial amount of information to satisfy us that value for money is being obtained.

294. What is the objective of the latest ministerial study announced by the Chancellor earlier this month?

*(*Mr *Heiser)* In the Autumn Statement it is stated, "The Government is reviewing the level and effectiveness of assistance for the inner cities. Meanwhile provision for the Urban Programme remains unchanged". Of course I cannot comment at the moment about confidential discussions taking place between Ministers but in looking at assistance going to the inner cities it is not just the Urban Programme; there are substantial sums of money which flow from other programmes towards the inner cities. For instance, the Manpower Services Commission's estimated exenditure for 1985–86 in the partnership areas was £100 million. The DTI with their innovation and small firms expenditures have a figure of £35 million in partnership areas and the Home Office are putting £12 million into the partnership areas under Section 11, which is support for local authority staff engaged on ethnic minority schemes. So there are different streams of money going into the inner cities which Ministers might be looking at in terms of effectiveness.

Mr Morris

295. Is monitoring now being done in all the Urban Programme recipients?

*(*Mr *Heiser)* It is being done in most; it cetainly will be done under the new arrangements which we have set in train because it is now a requirement. We believe that monitoring is carried out in a great many authorities but I could not say now that of the 105 authorities that receive some Urban Programme every one is carrying out monitoring or carrying it out systematically; a great many are and there is no doubt as far as we are concerned that the Urban Programme arrangements in the future will require that.

296. When will you be in a position to know whether every authority is undertaking such monitoring?

*(*Mr *Heiser)* When the first new IAPs are submitted following the introduction of this initiative and that will probably be next year.

297. Next year?

*(*Mr *Heiser)* In October next year we should see the first IAPs coming forward for the year of 1987–88 which actually reflect the full weight of the new initiative. But a great many authorities are already doing a great deal of monitoring and many will, because of the forms we have sent out and the discussions we have had, in so far as they are not doing it systematically, begin to put arrangements in hand.

298. Can we be assured as a Committee that the format of the monitoring will be identical in each authority in receipt of Urban Programme money and that we are not going to have a situation, as we found with the health authorities, where the criteria being used are different and therefore not comparable?

*(*Mr *Heiser)* I think you can.

299. You "think"?

*(*Mr *Heiser)* Yes. Of course all local authorities carry out financial monitoring now, they have to in a sense because they do not only have their own internal audit but they are subject to external audit; so financial monitoring will be taking place. What we are concerned with, particularly in this report, is to make sure there is good value for money monitoring, to see what we are

[Mr Morris *Contd.*]

getting for the money. I am sure that we will see this come through across the board. It has been developing steadily since the year the C&AG looked at which was basically 1983–84. There has not been systematic documentation but we are confident that we will get this.

300. You mentioned jobs created and there are a number of a definitions of jobs created. Are the Department able to tell us that there will be one definition used for jobs created on all the returns made in relation to the returns due next October?

*(*Mr *Heiser)* There is a list of 53 outputs which we have agreed and they do include that sort of measure. However, we shall have to distinguish between different types of output. For example for business support and training we not only ask for total number of grants and loans going to firms but jobs created and jobs preserved. We will get that as output measures; it is that sort of information that we are asking for. It is difficult of course because how long does the business stay? We can get information at the point in time at which it comes but we shall have to develop our own monitoring, sample monitoring, for longer-term follow-through and keep going forward with our programme of research evaluations to get some positive measures of how sustained these benefits are.

301. You mentioned an interesting attitudinal survey in Birmingham affecting a particular environment and the fact that people's attitudes become more positive. Are the Department issuing guidelines to authorities on the requirement for a regular assessment of attitudes because obviously it is only by testing attitude changes over time that you can be in a position to assess whether it is successful or not?

*(*Mr *Heiser)* No, we have not made that part of the Urban Programme Management initiative. We ourselves began an extensive programme of research and we intend to keep it up; other authorities like Birmingham do the same. We try to disseminate good practice and we would expect many authorities to do this kind of thing. Undoubtedly one of the points of the Urban Programme has been to try to draw in the local community, ethnic minorities, voluntary groups and firms. There is a growing awareness that it is important to understand what is happening among the recipients of the programme, to the people living in the area. It is not part of the Urban Programme Management initiative in a formal sense; we will however certainly carry out these studies ourselves and I have no doubt that many of the major authorities will want to do their own kind of studies in areas.

Mr Deakins

302. Why is it considered necessary to introduce effective monitoring? Is it because there have been doubts over the years about the effectiveness of what is being done and therefore a need for some machinery to oversee it?

*(*Mr *Heiser)* We all became very conscious of the need to secure value for money from the tax pound and the rate pound, particularly with the launch of the Financial Management Initiative across Whitehall. Indeed the first monitoring exercise in 1983 was prompted by several things: one was the Financial Management Initiative; the second was my own predecessor's concern, as he wanted to be satisfied as Accounting Officer that he could discharge his responsibilities in terms of value for money; and in all of the areas my Department is concerned with we have become very conscious of the need to try to get as much as possible from all the resources available. It really is part of that drive. This is partly why, when one looks back at 1981 one does not find that many output measures as such: it was in an early state of development and we have taken it quite a long way further. What we are quite convinced about is that we must, in value for money terms, make quite sure, as far as it is reasonable to do so, that we are getting the best value for putting the money into certain places in certain ways.

303. Would you make a distinction between monitoring and appraisal? I define appraisal as looking at the project after it is finished.

*(*Mr *Heiser)* In our terminology we use the word appraisal to mean looking at an application for a scheme. You ask yourself whether it fits the strategy in the IAP, whether it fits in with the local authority main programmes, and whether it is reasonable in cost terms. That is the way in which we use the term appraisal. We tend to use monitoring in relation to the completed scheme: what has it actually got in terms of intermediate and final outputs.

304. So you use monitoring in the way in overseas aid one uses the word appraisal.

*(*Mr *Heiser)* I am sorry if that is confusing but that is simply the language which has

[Mr Deakins *Contd.*]

grown up in this system. We think it very important to improve our initial appraisal and to improve monitoring. I would not pretend it is anything other than a learning curve. I repeat some figures I gave earlier: with 12,000 schemes running, very many small schemes and a huge variety of schemes stretching across economic development, environmental and social categories, one has to look very hard to be sure that we are getting the right schemes in the right place.

305. Is it possible to look back at the 12,000 or more schemes in recent years and say which categories on the whole have been the most successful and which have been relatively unsuccessful so that appropriate guidance can be issued in future?

*(*Mr *Heiser)* We do know something about successful schemes in the sense that a high percentage of innovative schemes are taken into the main programme. For instance, Birmingham's schemes for enveloping terraces, streets of private houses, by renewing the external fabric, were experimental schemes helped by the Urban Programme. They have been so successful that they are now part of the main housing programme and in fact in the last 12 months I understand that over 2,000 houses have been included in approved schemes by ten authorities. That is an example of an Urban Programme scheme, an innovative scheme, moving into the main programme. In Birmingham there was an Urban Programme scheme in ten primary schools, which was designed to associate parents with the school in developing community facilities. That has been so successful that Birmingham have taken that into their main programme. One can list many examples of that kind where innovative and new sorts of schemes have been absorbed into main programmes, which is a demonstration of one of the valuable aspects of the programme.

306. The new ministerial guidance which has been issued and which is set out in Appendix 5 seems to be rather more specific than previous guidance.

*(*Mr *Heiser)* Yes.

307. Is it more specific because you have looked at the whole of the Urban Programme over the decades and decided that these are the areas where there is most prospect for a successful outcome of expenditure of public money?

*(*Mr *Heiser)* It is fair to say that. If you look at the four objectives, however, one can-not claim great originality. The four main objectives are to improve employment prospects, to reduce numbers of derelict sites and vacant buildings, to strengthen the social fabric and reduce the number of people in acute housing stress. I would not care to say one has suddenly in 1985 seen that these were the things to do; there are certain sorts of scheme, particularly the economic development schemes, which create and preserve jobs, which improve confidence in an area, and where we are becoming a little bit more certain, and so are the authorities, that these are the right sorts of schemes to develop. It was interesting that the Chief Constable of Birmingham in his recent report on Handsworth quoted the scheme known as the Lozells scheme which was a UP scheme. It was designed to bring together leaders of the community, the council and the statutory bodies like the police and to produce measures which would improve the quality of life in the neighbourhood, reduce crime and reduce vandalism. He commended it very strongly and he noted that for the first time this sort of scheme had developed a very strong sense of cooperation and community; that is being continued in and expanded in the Ladworth scheme. There are schemes of this sort which are quite important and we need to identify them and bring them out and disseminate them as good practice.

308. One understands that the ministerial objectives have probably always been implicit in the programme but would you think that the new ones are a summation of what is considered best in the programme, what it is best at achieving, and that this is really where Urban Programme resources should be increasingly concentrated in the future?

*(*Mr *Heiser)* Yes. As we go on we might, and we expect to be able to identify classes and categories of scheme which are more successful than others. This is a very important part of our monitoring process. Individual authorities already do this and I quoted some instances. We would hope, being at the centre and being able to pull these things together, to be able to demonstrate or show what schemes have been particularly successful. It is also of relevance of course that there are many other programmes running. The Urban Programme is quite a small financial ele-

[Mr Deakins *Contd.*]

ment of the total expenditures going on in the local authority area and one has to have regard to those programmes as well.

309. Have any lessons been learned about the appropriate form of machinery within local government, whether it be in partnership areas or in other programme areas, where local authorities ought to adopt a certain pattern of organisation for best achieving the objectives or the Urban Programme? Or is it really left to individual local authorities to set up the appropriate machinery here?

*(*Mr *Heiser)* As between the Department and local authorities the programme does depend on mutual cooperation. There are very close working relationships between our regional offices and most local authorities at officer level. There are officer level topic groups looking at classes of projects and aspects of strategy. What a local authority does within its own boundaries ends when it looks outwards, to voluntary groups and others, we have taken the view, that it is a matter for them as the elected representatives. But we are concerned, as are many of these authorities, to disseminate good practice and machinery itself may well be one of those things which becomes part of what we want to examine, and discuss with other authorities.

Mr Latham

310. Since you pay for 75 per cent of this expenditure do you not think you should do a bit more than just disseminate information about good practice?

*(*Mr *Heiser)* I have probably not been as clear as I might. The answer is yes. The Urban Programme Management initiative does do that by laying out systematically what we expect now from IAPs and strategies, appraisal and monitoring. We also are continuing with our research projects to make quite sure that we understand what is happening and what is being secured.

311. I appreciate that but the operative word is "now" is it not? This programme has been going in one form or another since 1969 and if one reads through the report the feeling one gets is that for years and years and years the thing was allowed to build up and grow on its own and it produced a DOE survey of IAP documents in 1983 which revealed considerable deficiencies in content and quality. Since then a number of steps have been taken and improvements made which you described a moment ago. This is a matter of profound interest to the Committee of Public Accounts. Surely when initiatives are taken by Government—this one has been going since 1973–74—the objectives and monitoring structure should be put in place at the beginning and not ten years later.

*(*Mr *Heiser)* The programme was quite small to begin with. It is quite interesting to see how the programme has grown since 1979. In cash terms the figure I have at the moment—including Urban Development Grant which goes rather wider than the report—is £93 million in 1978–79; in 1985–86 the provisional figure is £338 million and that is an increase in cost terms of about 94 per cent. As it grew we began to get concerned and this is why we launched the 1983 guidelines monitoring exercise. Since then we have been trying to put in place—this has now come forward in the Urban Programme Management initiative—a systematic assessment. I hope I have said enough to show that although the C&AG commented that he could not find full documentation in a systematic way of all appraisal of strategies, and projects everywhere; in fact a good deal of this was going on in our regional offices through officer working parties and through constant discussion with local authorities. I have mentioned some of the outputs and measures and research projects which show what has been secured by the Urban Programme.

312. Yes, the C&AG did say that, but he also in paragraph 5.17 on page 15 contrasted the responses of your different regional offices, some of whom have questionnaires, some of whom have no questionnaires and no consultations and so on. Although I appreciate that this is all being changed and that is described on the next page and obviously it was a snapshot in time, the point I am trying to get at is if initiatives have been taken involving substantial sums of public money it is surely incumbent upon the Department to set in place its monitoring arrangements and its objectives from the word go and not to be hauled up by the C&AG ten years later and then to begin to put them into place?

*(*Mr *Heiser)* I can only repeat what I said. As the programme grew we became concerned ourselves to put something more secure and systematic in place and have now done so. Though the C&AG does comment on the varying performance of regional

[Mr Latham *Contd.*]

offices, at the time, and even now, it has to be understood that regional offices are dealing with different authorities who vary in their reaction to the Urban Programme. In some places, like parts of London, the concept of management by exception is difficult to run because virtually all schemes have to come forward to Ministers since there can be a profound difference of view between the authority and Government about objectives. So very much of the variation in performance between regions is a variation which relates to individual authorities. What I do accept—I do not quibble about this—is that we do need to have a more systematic documentation of what has happened. On many of the individual instances which the C&AG quotes—and I am willing to answer any particular point—we think we can show the regional office actually did have in place discussions and documents on most of the schemes that were being looked at at the time. What we do accept is that for instance in some cases the strategy was not to be found in the IAP or in one document.

313. Let us look forward now. You said that Ministers were discussing future policy in this regard following the announcement which the Chancellor made in the Autumn Statement and obviously this Committee are not concerned with that at this stage. I hope you can give us an assurance that if there are to be new initiatives taken on an inner city policy and whatever form they take—particularly if they involve public expenditure which many of us might very well want to support—they will have from the word "go" their monitoring procedures in place and you will also be able to say, "We have taken another initiative in inner city policy. We are going to do this, that and the other. This is the money we are allocating for it, this is what we want to achieve and this is how we are going to see the money has actually been spent in this direction." Is this a primary objective of your Department?

*(*Mr *Heiser)* Speaking for my Department, I give you an unqualified yes.

314. Are you taking the lead in this matter at the DOE because you must produce most of the money for inner city policies at this stage?

*(*Mr *Heiser)* In terms of putting good arrangements in place?

315. Yes.

*(*Mr *Heiser)* We can only put arrangements in place for what we are responsible. I do not have any doubt that other departments would give the same answer that I have now.

Mr Silvester

316. In Appendix 5 where you list the four categories of objectives for urban policy, are the schemes allocated to these (a), (b), (c) and (d), and if so can you indicate what the current spread of schemes is between the four categories?

*(*Mr *Heiser)* There is a slight overlap but we use three basic categories for analysis. We have economic, environmental and social. I can give you a break-down for those, particularly to show you the change, which might be interesting, between 1979–80 and 1985–86: 29 per cent were economic schemes in the first year, 34 per cent in 1985–86, so that has risen; 19 per cent environmental schemes in 1979–80 and it is now 23 per cent, so that has gone up; 51 per cent were social schemes and they are now 43 per cent so that has dropped. That reflects ministerial policies in trying to move towards economic and environmental schemes and away from social and towards capital schemes and away from revenue schemes. In giving those percentages it is important to bear in mind that these are percentages in the last year of a much bigger figure because in cost terms the programme has risen by 94 per cent over this period. So even though the social schemes have dropped as a percentage from 51 to 43 per cent, it is of a bigger figure. There is another breakdown which may be of interest on voluntary and ethnic schemes. The voluntary groups were 13 per cent in 1979–80 and they are now 28 per cent. I do not have a 1979–80 figure for schemes directed at ethnic minorities but in 1980–81 they were 3 per cent and they are now 12 per cent. There is one final breakdown I could give you on capital and current, if you are interested?

317. I am more interested in that one, what is it?

*(*Mr *Heiser)* It shifted on current from 39 per cent in 1979–80 to 34 per cent in 1985–86; on capital from 61 per cent to 66 per cent. The voluntary and ethnic and current and capital categories of course overlap with the three main categories I gave to begin with.

318. Sticking with current and capital and environment and economic and social, does that correspond with your assessment

[Mr Silvester *Contd.*]

of which have been the most effective schemes?

*(*Mr *Heiser)* It corresponds to ministerial judgment that one wanted to shift more to capital schemes, schemes which create factory units, workshops, infrastructure, so there was a general policy judgment behind that shift. In terms of the nature of the schemes, as the regional offices sift and approve schemes they do try to identify what in their experience are the better sorts of schemes when they exclude schemes—I mentioned we had rejected 7,700 schemes since 1979. Many of those rejections would be of schemes which were thought not to be suitable in the light of experience.

319. It is interesting that in all the examples you have given, where you have tried to indicate you have been successful, they have all been capital or environmental. I do not think you have quoted one—except perhaps one educational parental scheme—which was social?

*(*Mr *Heiser)* There are others. I mentioned the evaluation report which found the high satisfaction of residents in areas where there had been Urban Programme funded schemes on open space and parks.

320. I would call that environmental, would you not?

*(*Mr *Heiser)* Yes. By "social" you are thinking of community centres and things like that.

321. I am thinking of spending money on schemes which do not have an environmental or economic or capital background. The reason I am asking about this is that a lot of these schemes are schemes which would normally be thought to be the normal responsibilities of local authorities.

*(*Mr *Heiser)* The social schemes?

322. Yes.

*(*Mr *Heiser)* May I mention a few of these schemes?

323. I am really trying to get at the point which is that if you are dealing with current expenditure in particular you are dealing with schemes which are being funded under the Urban Programme because people are tight for money under other programmes?

*(*Mr *Heiser)* I understand the point and we have always been concerned about that. We have never wanted to accept achemes which should properly be funded under main programmes. When we carried out our first guidelines monitoring exercise we only found one scheme which we thought should have been funded under the main programme and the funding was discontinued. Many of the schemes rejected will be schemes which regional offices think belong to main programmes. The sorts of community schemes one looks at are rather like the project which was commended by the Chief Constable in Handsworth, which does not fit a main programme very exactly, where communities have been brought together with the statutory agencies to see what measures taken, based in the community, might reduce crime. It is not easy to fit that into main programme. Other schemes which one can quote are community care schemes and schemes for the under-fives which involve several different departments in a local authority—education and social services—where there is an innovative aspect and it prompts the authority to do some thing differently. These sorts of schemes have been absorbed into the main programme. So there are schemes of that sort which are social and do not fit very neatly to begin with into main programmes.

324. But when do your schemes cease to be innovative and have to go into the main programme? How long will you keep them going?

*(*Mr *Heiser)* In April 1984 local authorities have absorbed about 47 per cent of the time-expired schemes and they have gone into main programmes; 49 per cent have been renewed but that leaves 4 per cent which have simply run out—they have done their job, and they have not been seen fit for renewal. But there are some schemes, which because they involve bringing the voluntary groups in and are focused on ethnic minorities, do not fit very readily into main programmes. However, I agree with the point being made: some of the schemes being innovative either make the grade or do not and should be absorbed or not and that is the attitude we have adopted to them.

325. You would not normally expect to keep on renewing a scheme?

*(*Mr *Heiser)* No, the revenue schemes have a time-limited life of not more than five years but they can be renewed for a limited period. Very many of these schemes involve very small sums of money; every pound is important but they are not very large schemes very often in terms of revenue support.

[Mr Silvester *Contd.*]

326. There have been lots of pots of gold in which people dip different hands to build up a sum of money to run their particular interest. Is the establishment of the city action team relevant to this? Is that an entirely different operation?

*(*Mr *Heiser)* It has relevance because one of the important issues is the co-ordination of activity by Government departments. The City Action Teams were set up in the partnership areas to bring together my Department, the Department of Trade and Industry and the Department of Employment through the Manpower Services Commission to develop better co-ordination in the partnership areas. It was built upon what we already had and it has built a sense of shared responsibility in that the leadership of the CATs at official level is spread between the three departments and is under the oversight of Lord Young. The intention was and still is to make sure that we are co-ordinating our action as best we can to secure the maximum output in the city action teams. Government have not turned away the idea that the CATs might be extended geographically or extended to bring other departments in and indeed we do try already to associate ourselves with the social departments where they have a local representation.

327. Could you then assure me that if I were seeking to get money for a project—it does not matter what it is—and I applied for an Urban Programme grant and then I applied to somebody else—the DTI for example—I am not going to end up being able to extract money from different departments because they do not know what is going on in other departments?

*(*Mr *Heiser)* I think I can assure you of that because there are extremely close working relationships now in the regions between our departments and we are very, very conscious of it. Some schemes are financed according to their component parts from different sources. We work closely with the MSC on their community programmes with our Urban Programme. There are things which are proper for the Urban Programme and proper for the MSC and we work extremely closely with the other departments to see that a scheme makes sense and is integrated in a way which makes use of money in way which was intended by Parliament.

Mr Campbell-Savours

328. Was the Task Force that was set up by Michael Heseltine the forerunner of the city action teams? Is there some connection there?

*(*Mr *Heiser)* It was not exactly that because it is an office of my Department which is based in Liverpool, applying to Merseyside and it is solely dedicated to that particular area. The regional offices where CATs are based apply to whole regions: it is different in that way. Mr Sorensen was Head of the Merseyside Task Force until a year or two ago when he took over the Inner Cities Directorate.

*(*Mr *Sorensen)* It is fair to say that the principle of inter-departmental working, which was pretty heavily exploited by the Task Force, was a principle which is now being carried on in the city action teams. To that extent, the initative taken through the Task Force of inter-departmental working was a forerunner.

329. I am not sure but I think I met you in Liverpool two or three years ago. Is that correct?

*(*Mr *Sorensen)* I think that may well be the case.

330. What struck me at that time was how very deliberately and how very clearly you defined what the policies were to be in many areas. I wonder to what extent you learned lessons in the application of the policy under the Task Force and its implication for your Department for other areas? Has there been a spinover of that experience into other partnership areas and other parts of the country?

*(*Mr *Sorensen)* It was Mr Heseltine laying down the policy rather than me but under his direction we did have some fairly clear views about what should be done in the particular locality of Liverpool and Merseyside. Obviously different areas are different, different problems have different weights which should be attached to them. One cannot assume that one can simply replicate the particular breakdown of activity that we had in the Liverpool area in other areas. The general lessons we learnt on how to measure inputs and outputs—and we were very much on a learning curve at that time—and how difficult it was to mount some projects and relatively easy to mount others have been applied more generally.

331. Would you say that where you do have a sense of motivation—which I perceived as being very strong—it is easier to establish priorities and to establish a very

[Mr Campbell-Savours *Contd.*]

Clear series of policies in terms of applying these resources?

*(*Mr *Sorensen)* Motivation is always helpful. Whether motivation helps you to work out how best to use £1 million of public expenditure is a more difficult question.

332. Could you tell me to what extent there is overlap with the provision of urban development grants? Looking in as a politician I sense there is a rundown going on in one area and an increase going on in the other. Is there to some extent an overlap that you see in your own Department?

*(*Mr *Heiser)* We do not see it as overlap because the Urban Development Grant is focused particularly on securing leverage of private sector money. It is really focused on schemes where the private sector will want to develop housing projects, commercial projects, industrial projects, but need some sort of pump priming; it has been very successful in that sense. By October 1985 the approved UDG applications had provided about £328 million of private investment but they are focused very much on the schemes which are close to being profitable. The economic development Urban Programme schemes tend to be areas such as those I have mentioned like the Lace Market in Nottingham where it is not so much bringing in a specific firm but trying to regenerate an area and to attract firms and people back into the area.

333. But these are grants that are paid in areas where previously TUP would have been the only form of assistance available. Is that correct?

*(*Mr *Heiser)* Yes.

*(*Mr *Sorensen)* In some cases.

*(*Mr *Heiser)* If you wanted a note on this we could give it to you. I think the majority of UDG money would go into the areas we are now considering, the main Urban Programme.*

334. To what extent are we more effectively pursuing those public monies than we were the traditional Urban Programme monies, pursuing their use and monitoring their use?

*(*Mr *Heiser)* We are adopting the same approach to them as to the Urban Programme because it is all public money. Where it is going into the hands of private firms one is always very conscious that it is public money. Just as in the Urban Programme we have always been sensitive to this, we have been concerned on urban development grant to be quite sure the money is being properly and well spent.

335. Are you pressing local authorities to come forward with schemes? I notice that where my authority did submit traditional Urban Programme applications they have been a bit slow about applying for urban development grants and that is because they point to all sorts of difficulties. A report was produced by a Mr Nigel Smith in November 1984, which has probably been circulated in the Department and which outlines these particular difficulties. I know this was not quite covered in the report but to what extent have those comments been taken on board in relation to urban development grant allocations?

*(*Mr *Heiser)* I think they have. The point about the Urban Development Grant application is that it does involve a private firm with a specific project. We do have private sector secondees who look at these projects for us and appraise them because they do involve deep commercial consideration. Part of the problem may be the need for the local authority to prove that it is a good and well-founded application. Our regional offices are certainly anxious to secure good, well thought out UDG applications but some applications are not sufficiently well thought out in terms of value for money.

336. But have Mr Smith's comments been taken on board?

*(*Mr *Heiser)* Yes.

337. On paragraph 3.5 on page 10 I refer to an answer you gave to the Chairman when you were talking about the designation of areas and who gets what. It says, "For example, a ranking based only on the deprivation indicators used in DoE's analysis would suggest that three Partnership Authorities appear to suffer from less severe deprivation than some 20 other authorities granted Programme Authority or ODD status only." What I sense from that paragraph is that there is a little bit more than the statistics, perhaps even a little bit of subjective judgment about these matters. Is that correct?

*(*Mr *Heiser)* I quoted Newcastle and Gateshead. Governments take the best judgments they can on the lines of all the information available.

338. It is just that if one writes into a Government department and asks why one has been removed from the list, which is obviously a matter of controversy to

*See Appendix 1, page 14.

[Mr Campbell-Savours *Contd.*]

members, one gets the answer that the resources are being routed into particular areas where problems are greater and that those areas fall within the parameters drawn from these indices to which you have referred. Yet I sense from the Comptroller and Auditor General's report that there is perhaps a little bit more political consideration and subjective judgement than perhaps might meet the eye at first glimpse?

*(*Mr *Heiser)* There has been very little movement on the partnership and programme and other designated districts list; they stayed more or less the same until 1983 when in fact eight were added to programme and three to other designated districts. Some came off the partnership authorities in 1981 but they were in the areas where the Docklands Corporation was at work and it was thought right therefore to put them lower down the list. Authorities taken off have been largely the TUP authorities, the Traditional Urban Programme authorities, who are not listed in Appendix 1 and who get relatively small sums of money. There Ministers have taken a view this year that it would be best to concentrate the sums that go to the TUP authorities on fewer authorities.

*(*Mr *Sorensen)* We are reasonably satisified as a Department that the basis on which we could concentrate the Traditional Urban Programme resources to a smaller number of authorities than has been the case in the recent past, was reasonably well founded. Our problem is that one can only measure deprivation by the statistics which are readily available and which are transferable between areas. Therefore we do tend to lean on census data. We do not have such good measures in some sense for economic deprivation as for the proxies for social deprivation. It is partly simply a case that the statistical information is not available in a form that we can use. To give you one example, if an area has a weak economic base and if it is assumed therefore it is deserving of Urban Programme support, it is quite difficult to devise a means of how you would measure a weak economic base. So it is devising indices and getting a range of information which is one of the perennial difficulties in all this.

Mr Latham

339. Mr Jones, is this programme cash limited?

*(*Mr *Jones)* Yes, it is.

340. Is it spent up to its cash limit?

*(*Mr *Jones)* There was a little underspending in the last financial year.

341. May we know what the outturn was?

*(*Mr *Sorensen)* I cannot tell you what the outturn was for 1984–85 but Mr Jones is right that it was underspent slightly this last financial year. We have just done a monitoring exercise for this financial year and we think we are reasonably on target.

*(*Mr *Heiser)* We could give you the figures on outturn if you want.

342. In a note if you would please.

*(*Mr *Sorensen)* The cash limit refers to capital and not current.

343. What would be helpful to me and I suspect the Committee as a whole would be to compare Appendix 2 allocations with outturn, at least for the last three or four years at any rate.

*(*Mr *Heiser)* We can give you a note of the outturn where it is available.*

344. Are the Treasury satisfied that the UPM has now got the checks and balances in the right form and that you are able to monitor it effectively in the way that you want to do so?

*(*Mr *Jones)* We are confident that it will bring a great improvement on what we all accept was an unsatisfactory situation before 1983.

Mr Campbell-Savours

345. If there is an underspend, do I presume that you do what many departments do and that is to ring round and ask who wants the money and who can spend it?

*(*Mr *Heiser)* Not at all. Treasury actually keep a close eye on any underspends.

Chairman: Thank you for coming to give your evidence today.

*See Appendix 1, page 14.

APPENDIX 1

Supplementary Evidence by the Department of the Environment (PAC 45)

URBAN PROGRAMME
'AREAS WHERE UDG IS AVAILABLE'

Question 333

In considering applications for UDG, priority is given to urban areas with serious social needs. Formal invitations to submit applications for Urban Development Grant (UDG) have been extended to the County and District Councils in England for districts which have been designated under the Inner Urban Areas Act 1978, or which have Enterprise Zones.

The sites of approved UDG projects are not necessarily located within Enterprise Zones or within the immediate areas which have given rise to designation under the 1978 Act, but such projects are always expected to contribute directly to the alleviation of special social needs in inner urban areas and to their economic or physical regeneration.

The distribution of UDG approvals, up to November 1985, is as follows:—

	£m	
Partnerships	31.0	41%
Programme authorities	32.2	42%
Other Designated Districts	5.9	8%
Elsewhere	6.9	9%
	76.2	100%

Question 343. OUTTURNS

Urban Programme Allocations and Outturns 1983–84 to 1985–86

£m	1983–84		1984–85		1985–86	
	Allocation	*Outturn*	*Allocation*	*Outturn*	*Allocation*	*Est Outturn*
Partnership and Programme authorities	204	218.5	224	229	224	234
Other Designated Districts	6.5	7.5	8	8	8	8
Trad UP	52	53	44	45	40	45
Urban Development Grant	60	7	48	15	40	25
Other	25.5	25	24	24	26	23
Total	348[A]	311[x]	348[A]	321[y]	338	335[z]

[A] Split of allocations differs marginally from that given in Appendix 2 of NAO report, but is on a basis compatible with the outturn figures.

[x] after transfers of £0.6 million to Sports Council and £0.35 million to land registry for initiatives on Merseyside; and £25 million to Urban Development Corporations UDCs.

[y] after transfer of £10 million to UDCs. In addition £14 million was allocated under end-year flexibility arrangements for Derelict Land Grant (DLG), UDC and UP expenditure 1985/86.

[z] this reflects transfers out of £6 million for initiatives on Merseyside under other DoE programmes (UDCs, DLG, Historic Buildings and Monuments Commission (HBMC)), and a transfer in of £3 million under end-year flexibility arrangements.

Commentary

The Urban Programme itself is not, as a whole, formally cash limited, but it is managed as if it was. The Urban Programme *capital* expenditure (some two thirds of the programme) however forms part of the Urban Block, and the cash limit applies to this block, which also includes Derelict Land Grant and Urban Development Corporations. In common with other local authority current expenditure, UP current expenditure is not cash limited.

The capital expenditure of the UP involves a substantial amount of construction work, and it is difficult for authorities to ensure a precise outturn in the financial year. If an authority exceeds its allocation, it does not receive grant on the excess.

The following arrangements have been developed to improve the management of expenditure:

a. a certain amount of overprogramming is undertaken, so that local authorities have projects approved and ready to bring forward from the following year's programme should slippage occur;

b. close liaison between Regional Offices and authorities ensures that resources can be moved between authorities in the event of slippage;

c. the establishment of the Urban Block has enabled the Secretary of State to switch resources within the financial year between UP, DLG and UDCs according to the progress of capital programmes. This has been particularly useful in maintaining the momentum of UDCs by taking advantage of the slow growth of UDG;

d. improved end-year flexibility arrangements mean that up to five per cent of the capital resources in the Block can be moved between years. This greatly reduces any tendency to rush lower priority projects through at the end of the financial year.

In 1984–85, the Urban Block's first year of operation, the total provision for capital and current expenditure under the Programmes comprising the block was £485m, and the outturn, including £14 million carried forward to 1985–86, was £477 million.

25 *November* 1985.

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THIRD STANDING COMMITTEE ON STATUTORY INSTRUMENTS, &c.

MINUTES OF PROCEEDINGS

ON THE

DRAFT MISUSE OF DRUGS ACT 1971 (MODIFICATION) ORDER 1985

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The Committee was constituted as follows:—

Mr. PATRICK CORMACK appointed Chairman, 20th November

Mr. Allen Adams
Mr. Nicholas Baker
Mr. Tim Brinton
Mr. Alex Carlile
Mr. Bob Clay
Mr. Robin Corbett
Viscount Cranborne
Mr. Peter Fry
Mr. David Heathcoat-Amory
Mr. Nicholas Lyell
Mr. Tony Marlow
Mr. David Mellor
Mr. Michael Neubert
Mr. Patrick Nicholls
Mr. Richard Ottaway
Mr. Terry Patchett
Mr. Laurie Pavitt
Mr. David Young

PROCEEDINGS OF THE COMMITTEE

Tuesday 26th November 1985

MEMBERS PRESENT

Mr. PATRICK CORMACK, in the Chair

Mr. Allen Adams
Mr. Nicholas Baker
Mr. Tim Brinton
Mr. Robin Corbett
Viscount Cranborne
Mr. Nicholas Lyell
Mr. Tony Marlow
Mr. David Mellor
Mr. Michael Neubert
Mr. Patrick Nicholls
Mr. Richard Ottaway
Mr. Terry Patchett

DRAFT MISUSE OF DRUGS ACT 1971 (MODIFICATION) ORDER 1985

Resolved, That the Committee has considered the draft Misuse of Drugs Act 1971 (Modification) Order 1985.—(*Mr. David Mellor.*)

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DRAFT PUSHCHAIRS (SAFETY) REGULATIONS 1985—Referred to a Standing Committee on Statutory Instruments &c. on 12th November 1985; allocated by Mr. Speaker to the First Standing Committee on Statutory Instruments, &c. on 13th November.

The Committee was constituted as follows:—

Mr. TED LEADBITTER appointed Chairman, 14th November

Mr. Guy Barnett
Mrs. Virginia Bottomley
Mr. Graham Bright
Mr. Robert C. Brown
Mr. Alistair Burt
Mr. Richard Caborn
Mr. Roger Gale
Dr. Norman A. Godman
Mr. Harry Greenway
Mr. Michael Hancock
Mr. John Hannam
Mr. Christopher Hawkins
Mr. Robert Hayward
Mr. Kenneth Hind
Mr. Michael Howard
Mr. Dave Nellist
Mr. Geoffrey Robinson
Mr. Donald Thompson

PROCEEDINGS OF THE COMMITTEE

Tuesday 26th November 1985

MEMBERS PRESENT

Mr. TED LEADBITTER in the Chair

Mrs. Virginia Bottomley
Mr. Graham Bright
Mr. Alistair Burt
Mr. Roger Gale
Dr. Norman Godman
Mr. Harry Greenway
Mr. John Hannam
Mr. Robert Hayward
Mr. Michael Howard
Mr. Geoffrey Robinson
Mr. Donald Thompson

DRAFT PUSHCHAIRS (SAFETY) REGULATIONS 1985

Resolved, That the Committee has considered the draft Pushchairs (Safety) Regulations 1985.—(*Mr. Michael Howard.*)

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FOURTH STANDING COMMITTEE ON STATUTORY INSTRUMENTS, &c.

MINUTES OF PROCEEDINGS
ON THE

DRAFT INDUSTRIAL TRAINING LEVY (CONSTRUCTION BOARD) ORDER 1985

Ordered by The House of Commons *to be printed*
26th November 1985

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The Committee was constituted as follows:—

Mr. HARRY GOURLAY appointed Chairman, 20th November

Mr. David Atkinson
Mr. Robert Banks
Mr. Andrew Bowden
Mr. Richard Caborn
Mr. Bernard Conlan
Mr. John Evans
Mr. Nigel Forman
Mr. Richard Hickmet
Mr. Terry Lewis
Mr. David Lightbown
Mr. Robert Litherland
Mr. Peter Lloyd
Mr. Robert McCrindle
Mr. David Marshall
Mr. Colin Moynihan
Mr. Anthony Nelson
Mr. David Trippier
Mr. Richard Wainwright

PROCEEDINGS OF THE COMMITTEE

Tuesday 26th November 1985

MEMBERS PRESENT

Mr. HARRY GOURLAY, in the Chair

Mr. David Atkinson
Mr. Robert Banks
Mr. Andrew Bowden
Mr. Terry Lewis
Mr. David Lightbown
Mr. Robert Litherland
Mr. Peter Lloyd
Mr. Robert McCrindle
Mr. Colin Moynihan
Mr. Anthony Nelson
Mr. David Trippier

DRAFT INDUSTRIAL TRAINING LEVY (CONSTRUCTION BOARD) ORDER 1985

Resolved, That the Committee has considered the draft Industrial Training Levy (Construction Board) Order 1985.—(*Mr. David Trippier*).

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MINUTES OF PROCEEDINGS

ON THE

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DRAFT MERCHANT SHIPPING (PREVENTION OF OIL POLLUTION) (AMENDMENT) ORDER 1985—Referred to a Standing Committee on Statutory Instruments &c., on 12th November 1985; allocated by Mr. Speaker to the Second Standing Committee on Statutory Instruments, &c. on 13th November.

The Committee was constituted as follows:—

Mr. JOHN SPENCE appointed Chairman, 14th November

Mr. Robert Adley
Mr. Gordon A. T. Bagier
Mr. Michael Brown
Dr. Michael Clark
Mr. Bob Clay
Mr. Tom Cox
Mr. Cecil Franks
Mr. Peter Griffiths
Mr. Peter Lilley
Mr. David Maclean
Mr. Francis Maude
Mr. David Mitchell
Mr. David Mudd
Mrs. Marion Roe
Mr. Roger Stott
Mr. Jack Thompson
Mr. Alec Woodall
Mr. Ian Wrigglesworth

PROCEEDINGS OF THE COMMITTEE

Tuesday 26th November 1985

MEMBERS PRESENT

Mr. JOHN SPENCE in the Chair

Mr. Michael Brown
Mr. Bob Clay
Mr. Cecil Franks
Mr, Peter Griffiths
Mr. Peter Lilley
Mr. David Maclean
Mr. Francis Maude
Mr. David Mitchell
Mr. David Mudd
Mrs. Marion Roe
Mr. Alec Woodall

DRAFT MERCHANT SHIPPING (PREVENTION OF OIL POLLUTION) (AMENDMENT) ORDER 1985

Resolved, That the Committee has considered the draft Merchant Shipping (Prevention of Oil Pollution) (Amendment) Order 1985.—(*Mr. David Mitchell.*)

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HOUSE OF COMMONS

EDUCATION, SCIENCE AND ARTS COMMITTEE

Session 1985–86

FIRST SCRUTINY SESSION

MINUTES OF EVIDENCE

Tuesday 26 November 1985

— Higher Education: student awards: NAB review of teacher training places
— Teachers' Pay and Conditions of Service
— Default Powers of the Secretary of State (Poundswick)
— LEA Management of Resources
— Preparation for GCSE
— Teacher Supply
— Autumn Financial Statement: Engineering and Technology Programme: science budget: school buildings: polytechnics
— Miscellaneous: LEA support for lesbian groups: departments of architecture in universities and polytechnics: free speech in the universities

Department of Education and Science
Rt Hon Sir Keith Joseph, BT, MP, Mr R H Bird, CB, Mr W O Ulrich, Mr P H Halsey, LVO, and Miss J A Gilbey

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MINUTES OF EVIDENCE TAKEN BEFORE THE EDUCATION, SCIENCE AND ARTS COMMITTEE

TUESDAY 26 NOVEMBER 1985

Members present:

Sir William van Straubenzee (Chairman)

Mr Jim Callaghan
Mr Martin Flannery
Mr Clement Freud
Mr Harry Greenway
Mr Roger Sims
Mr Jack Thompson
Sir Gerard Vaughan

Examination of Witnesses

RT HON SIR KEITH JOSEPH, BT, MP, Secretary of State for Education and Science, was examined.
MR R H BIRD, CB, Deputy Secretary, Further and Higher Education and Science, MR W O ULRICH, Deputy Secretary, Architects, Building and Schools, MR P H HALSEY, LVO, Deputy Secretary, Teachers, External Relations, Statistics and Computing Services, Pensions and MISS J A GILBEY, Assistant Secretary, Public Expenditure, Vote Estimates, the Department of Education and Science; were called in and examined.

Chairman

1. Good morning. Secretary of State, we are once again much obliged to you for coming to see us. We have a list of those who accompany you but I can see at a glance, having the privilege of knowing some of those with you, that the list is slightly out of gear because I hear that Mr Stuart is unwell and that Miss Gilbey has taken his place. You are accompanied by Mr Bird, Deputy Secretary, Further and Higher Education and Science; Mr Ulrich, Deputy Secretary, Architects and Building and Schools and Mr Halsey, Deputy Secretary, Teachers, External Relations, Statistics and Computing Services and Pensions—a busy man; as, I am sure, are the others, too. Secretary of State, we have given you notice that there are four main headings under which, please, we should like to raise matters with you. They are higher education, with particular emphasis—although not exclusively—on the future of student awards; teachers' pay and conditions, preparation for the GCSE and teacher supply and a few immediately topical matters briefly at the end. This means that we must impose upon ourselves on this side of the table a pretty close discipline because otherwise we shall never get through in the time we have this morning; so that we are all agreed that we shall try to be brisk and brief in our questioning. I shall merely set the ball rolling under the first heading. What was the thinking in your mind that brought you to abandon the consultative document which you had in mind and talked about on one of the last occasions that you were with us on the question of student support?

(Sir Keith Joseph.) I had hoped, Chairman, that the Government would accept the proposals I had put to my colleagues for a partial replacement of grants for students by loans; and that would have been, in my mind, the central theme of the consultative paper had my colleagues, in fact, agreed, with my proposal. But I was disappointed not to receive the approbation of my colleagues. The Government announced that the idea of partial or total replacement of grants by loans was, at any rate for the time being, off the agenda and, on examination of what remained of the consultative paper, I decided that there was nothing worth publishing.

Mr Freud

2. Sir Keith, with £840 million involved, how can you justify not producing some options?

(Sir Keith Joseph.) Because the options might have led people to expect more expenditure and there is no more expenditure in the Government's mind available for this particular purpose. Had partial loans been considered, there might, over the years, have emerged some savings which could have putatively been to some extent used for changes in the system that might have cost more money and thus have justified a consultative paper. With the removal of the partial loans possibility, that balance fell apart.

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[Mr Freud *Contd.*]

3. If there are no options, is it right for the DHSS to make decisions about students; and if that is the case, will you at least tell us?

*(*Sir *Keith Joseph.)* It is quite true that the DHSS, in their Green Paper on benefits, have suggested that there might be change in the short term support of students. If the DHSS and the Government go down that path, I understand that there will be a consultation period given for any proposals that are made.

4. And if the DHSS's White Paper makes constructive proposals about student awards, will you at least publish a document?

*(*Sir *Keith Joseph.)* I repeat that the DHSS proposals will not, in themselves, be primarily about awards but about possible changes in the supplementary benefit arrangements and other welfare benefits for students which, if changed, might to some extent have implications for student maintenance; and, if such proposals are made, there will be a consultation period.

Sir Gerard Vaughan

5. I am sure, Secretary of State, that we all understand your difficulties over this but the present situation is widely viewed, I would say, as unsatisfactory. From what you say, does that mean—and I cannot believe that you think it is satisfactory—that you are going to leave the situation exactly as it is; or what have you in mind now?

*(*Sir *Keith Joseph.)* There are two possible attitudes to the unsatisfactory state of the present position. Students, and those who speak for them or sympathise with them, may feel that the present maintenance is not in many cases enough. I do not in general share that point of view. I think that students are a privileged minority on their way to—on the whole and in general terms—careers with both interest and good earnings prospects and that there is a limit to what the general taxpayer should be asked to find by way of maintenance. The students are already provided free by the taxpayer—and, in some cases, the ratepayer—with all their tuition expenses. It adds up to a very large amount of money in total. The grants are meant for maintenance and there is a balance to be held between those who provide the grants—the taxpayers and the ratepayers, who will not benefit from higher education in most cases or from either the personal satisfactions or the access, on the whole, to higher career earnings—and the students who are going to benefit under both heads. I am one who believes that the balance has been a bit too much against the taxpayer and ratepayer; so that I repeat that there are two directions from which dissatisfaction may be entertained.

6. If I may ask a very quick supplementary question to that, are you saying then that you propose to leave the situation exactly as it is for the foreseeable future?

*(*Sir *Keith Joseph.)* "Exactly as it is" goes a bit far because each year, when putting to Parliament proposals for student maintenance grants, we do introduce some generally relatively modest changes that meet some particular arguments for improvement. I certainly do not wish to dismiss such possibilities in future. But they will be relatively modest.

Mr Sims

7. Are you satisfied, Sir Keith, with the present distinction drawn between mandatory and discretionary awards, bearing in mind that you now have the situation in some colleges and institutions where some students are receiving awards and others not; simply according to which local education authority area in which they live? Have you been giving any consideration to this? Do you anticipate any change in this field?

*(*Sir *Keith Joseph.)* No, Chairman, I am not satisfied. I do not see how anyone could be satisfied with the boundary line between the two or with every detail of the present arrangements. But changing the position would probably mean more expenditure, more expenditure that might conceivably have been considered had the Government moved towards partial loans but which is not at present conceivable under current constraints.

8. Thank you. Have you given any thought to the mechanism by which the awards are made? You will be aware that NAB and the Jarratt Committee have drawn attention to the system whereby the local education authority grants the award, pays it to the institution and then claims from central Government for the sum involved—which does seen a rather cumbersome and presumably expensive method of administering awards?

*(*Sir *Keith Joseph.)* May I ask Mr Bird to reply to that?

*(*Mr *Bird.)* I think that the question relates to fees, Chairman—that is to say, the standard rate of tuition fee which is charged—rather than to student maintenance.

[Mr Sims *Contd.*]

9. Yes?

*(*Mr *Bird.)* Certainly, the Government has noted the Jarratt recommendation which repeats similar recommendations which have been made in the past. It is the case, of course, that, although much of the money is, in a sense, re-cycled, there are some students who pay their own fees. There is, therefore, a financial cost to be taken into account in considering the change recommended. There are other factors such as whether it is desirable—as, indeed, the predecessor of this Committee recommended following the Robbins Report—that there should be fees, even if they are met in this way. These matters are under study but I cannot say when the Government will have reached any decision to make a change or to persist with the present arrangements.

10. But pushing these pieces of paper around must be a fairly expensive operation. One would have thought that, in these days of computers, there would be a far simpler way of dealing with this matter?

*(*Mr *Bird.)* It may be possible to apply information technology to simplifying the present system without changing the basis on which fees are levied and this money reaches institutions.

Mr Flannery

11. Sir Keith, you know that the National Union of Students has long asked for the abolition of parental contributions. You keep putting this up, although large numbers of parents do not even pay it. Therefore, the student is in a very difficult position. Would you agree with me, and with their union, that it is an infringement of the rights of students, young persons, that they should be so dependent on their parents and not be steadily freeing themselves of such a situation and have a grant in their own right which has nothing to do with parents?

*(*Sir *Keith Joseph.)* I was entirely with Mr Flannery for the first part of his remarks, Mr Chairman. But when he introduced his questions of rights, I am not quite so sure that I sympathise. There is no right to higher education at the expense of the taxpayer and ratepayer in this country. It is an arrangement which we have made—unlike that for compulsory school education which, from 5 to 16, requires that the taxpayer and ratepayer pay for free education. I agree with Mr Flannery that the present position with parental contributions is very unsatisfactory. But with the present constraints on public spending I do not see a way of relieving it.

12. Would you answer the other part of the question, Sir Keith: that you keep putting up that contribution so that in fact you are trying to curb the contribution of the taxpayer by asking the parents to give more and more and more. That seems to me to be quite wrong?

*(*Sir *Keith Joseph.)* I can sympathise with Mr Flannery and with the parents. It is quite true that last year the Government mitigated the full increase that I had originally proposed in the contributions of parents from those households with above a certain income. But, Mr Chairman, Mr Flannery is quite right: we still increased the contribution to a significant extent. That was done only because of the urgent need, the widely accepted urgent need, for some extra money for basic scientific research. It seemed to me in the interest of the country to re-deploy some funds in the way that Mr Flannery indentifies. It is not an ideal situation, I accept. Nevertheless, it remains true that support for students from the taxpayer and ratepayer is more generous in this country than is true of any other country known to me in the Western world.

Mr Freud

13. Sir Keith, what are your relations with NAB at the moment on the subject of teacher training?

*(*Sir *Keith Joseph.)* I have asked the National Advisory Body to advise me on the allocation of initial teacher training courses such that cost-effective and educationally effective courses to meet an increasing demand for primary school teachers and a reducing demand for secondary school teachers shall be provided. I have asked for that. I turn to my colleague concerned to ask whether the latest exchange with NAB has been published. If so, I will describe it.

*(*Mr *Bird.)* Either it was published yesterday or it will be published today. I am not quite sure.

*(*Sir *Keith Joseph.)* May I therefore assume that either it is published today or was published yesterday and go on to describe the further phase. The NAB received the request from me and explained that they would only be able to respond to it at such a time as seemed to me too late for the allocations that I require to make for 1987. I have, therefore, replied to them and this is what either was published yesterday or is

[Mr Freud *Contd.*]

being published today. I say that I regret that I must really ask for their advice earlier than they have planned; that I very much hope that they will see fit to give me that advice earlier than they planned; and to warn them that if they felt unable to do so, I would have to ask officials to give me advice by a deadline that would enable me to make allocations for 1987.

14. Would that deadline be the same deadline as you gave the NAB?

*(*Sir *Keith Joseph.)* May I turn to Mr Bird on this; because I cannot give a precisely accurate answer on that without consultation. Will it be the same deadline, Mr Bird?

*(*Mr *Bird.)* If the Secretary of State carried through the procedures himself, the result would be known in July and would then feed in for NAB's purposes in to their general planning exercise which will be running on through the latter part of the year——

*(*Sir *Keith Joseph.)* Next year!

*(*Mr *Bird.)* Indeed, 1986, in relation to 1987 and the following two years. If NAB accepts the Secretary of State's further invitation and produces advice by May, which is the date requested, then it may be that the final determination would not be made until September, allowing the time between May and September for any necessary consultations.

*(*Sir *Keith Joseph.)* For consultations and for the holder of my office and the Government to make any decisions on whether to accept the full advice or not.

15. So you feel that you can outperform NAB?

*(*Sir *Keith Joseph.)* It is really not quite like that. It is that if I do not get the advice from the advisory body in sufficient time, allowing for consultation and decision making, to feed into the allocation procedure for 1987, I shall really have, *faute de mieux*, to ask officials to do it. It is not ideal.

Chairman

16. I think that perhaps we should be drawing together the threads of this section if we are to keep to our timetable. May I ask the last question? Secretary of State, what were the considerations which led the Government not to proceed with the loan scheme for students, other than the rooted objections of the Chairman of this Committee?

*(*Sir *Keith Joseph.)*——which must have been very persuasive! But, unfortunately, from my point of view, the rooted objections of the Chairman of this Committee are shared by quite a number of other people and my best arguments failed to change their minds. I stand by my views that, as between the taxpayers and the ratepayers on the one hand and the students on the other, the argument should still be open, I believe.

Chairman: I think that that has been very helpful. Thank you, Secretary of State. We move on to teachers' pay and conditions and I shall hand the mike straight over to Mr Flannery.

Mr Flannery

17. Sir Keith, we are in—as some people might say—the middle or towards the end of the most damaging dispute in education that there has ever been in the history of British education; and there is no sign of an end to it. In the "Guardian" this morning, one of the most deeply experienced correspondents, Mr John Fairhall, says: "What a by now desperate Sir Keith"——and I do not necessarily agree with the word, "desperate"——"still will not accept is that the root of the teachers' dispute is just that the ordinary teacher is not paid enough money." Is it not a fact that that is the cause of the dispute, that a very moderate section of the community is in one of the longest strikes and industrial actions ever; and that on Scale 1 and Scale 2, for instance, while you call them professionals, the Government is paying them a miserable pittance compared with what other professionals get? Is that not the root cause of the struggle?

*(*Sir *Keith Joseph.)* Mr Chairman, in reply to Mr Flannery, may I go over some of the recent relevant history? Up till about two years ago, teachers certainly grumbled about their pay. I do not dispute that. But up till about two years ago there were ample candidates for entry to teacher training institutions—candidates who I was told were of the right quality—who sought entry with full knowledge of the career and pay prospects ahead of them. Admittedly, we have found it impossible, as previous Governments have found, to recruit enough teachers of the right quality in certain shortage skills such as mathematics, physics and craft. That has been a long-standing problem. But I repeat that up till two years ago, despite considerable grumbling, there were enough candidates coming forward—more than enough candidates coming forward—of the right quality. Moreover, up till about two years ago there were very few,

[Mr Flannery *Contd.*]

if any, anecdotes of good teachers quitting the profession. But, over the last two years, all these factors have deteriorated. That is to say it is even harder to find teachers of the right quality in shortage subjects. The abundance of candidates of the right quality for entry into teacher training has diminished and there are now all too many anecdotes—which I believe—of good teachers quitting the profession. So, in the light of this change in the climate of recruiting and retaining teachers of the right quality, the Government considered it necessary to change the career and pay structure: and, about 18 months ago, I offered on behalf of the Government an unquantified bargain which the Government would consider financing if it were to be affordable and if it were to offer the children a better education. Negotiations on that bargain, admittedly on an employers' offer which I did not entirely like, broke down in December 1984 when the National Union of Teachers walked out. I apologise for a long answer, Chairman, but Mr Flannery has asked me an important question. Consequently, I returned in August this year to quantify the additional money that the Government offered—namely, £1,250 million over four years—on condition that the teachers accepted terms of service and accepted a career and promotion profile oriented towards rewarding effective classroom teachers. Mr Chairman, the teachers' unions have so far totally failed to consider that offer or conditional offer of additional money. Had that offer been accepted, the pay of one-third of the teachers would have been sharply increased, the pay of a further one-third would have been significantly increased—both increases in addition to that annually negotiated for teachers' pay—and no fewer than 70,000 extra promotions would have been provided. I think that had that offer been accepted, at least for negotiation, the grumbles to which Mr Flannery legitimately referred would have been largely eased. I very much regret that the teacher unions have turned down the offer out of hand.

18. It is quite obvious, surely, Sir Keith, that the reason people do not leave the teaching profession for other professions, other jobs, is that there is mass unemployment and there is nowhere else to go. That is fundamental. But I want to ask you another question and make a comment. The other question is this. The re-arrangement of the Burnham Committee looks very much like gerrymandering and changing the goal posts in the middle of the game. When you tie re-assessment to this year's wage demand, surely you are doing something which could be done later; and the teachers agree that re-assessment could be discussed later. They are not against it. But to tie it to this year's wage demand is to cause quite unnecessary trouble and to convey the impression that you are not eager to finish with this year's wage demand by tying that to it. What do you think of that?

(Sir Keith Joseph.) The Government initiated the review of the Burnham Committee at a time—I forget the exact date but it was in the Spring of this year—when there was no reason to expect that the dispute would still be continuing in the late Autumn. The statute gives the holder of my office the power, the right, to alter the composition of the teachers' panel in recognition of the relevance of the numbers of the teacher union membership. It is not I who precipitated the change in the composition of the panel; it is the very large number of thousands of teachers who ceased to be members of the National Union of Teachers by their own will. On the second issue, appraisal is only one of the conditions that the Government sought to embody in teachers' terms. The Government remains firmly of the belief that we shall not get better schools until the teaching profession accepts, as a profession should, that it has certain obligations from which it cannot withdraw to the damage of the children if it is to be treated as a profession. So I make no apology for applying that to the additional money that the Government has offered the condition which we have applied.

19. I should like to ask Sir Keith—and I did not want to trespass upon the time of the Committee for longer—just one question. It is this. There is no end in sight to this, even after the Burnham Committee meets. The teachers will be bitter and disillusioned and a very large section of the general public supports them. Do you intend to stand rigidly and obdurately on the position you now occupy in regard to teachers' pay?

(Sir Keith Joseph.) I must say in reply to Mr Flannery that I do not think the action that teachers in large numbers are taking to disrupt the education of children can in any way, Chairman, be justified. Obviously, I have no quarrel with their bargaining or negotiating with their employers and, through their employers, with the Government. But I regard it as utterly, utterly wrong and indefensible to damage the

[Mr Flannery *Contd.*]

education of children. I know that many teachers are anguished by the disruption they are individually contributing to cause; but they are free human beings with free will and a mind of their own and they do not need to disrupt. I pay tribute to those many teachers in all unions—and to the entire membership of one union; and I pay tribute to the heads and deputy heads—who have put the children's interests first.

Mr Greenway

20. A brief question, Sir Keith. Hundreds and thousands of——

*(*Sir *Keith Joseph.)* May I complete my last answer from which I left one thing? Therefore, I do regard it as the duty of teachers to cease disrupting. It is their initiative which has led to the disruption and they have an offer that could be revived if they showed interest in it, an offer which would transform the career and promotion prospects; and it is to the teachers that the public should look to cease disrupting. I apologise for interrupting Mr Greenway.

21. My question ties in with what you are saying, Sir Keith. Hundreds of thousands of children are being sent home every week and similar numbers every day, now without warning to parents. They go into school, they have lesson one and they may then be sent out on to the street for the next three lessons. The concern of parents and public is very great. Have you any idea of what can be done to overcome this situation; and it includes very young children?

*(*Sir *Keith Joseph.)* I can only repeat that I think it is even more wrong of teachers to disrupt children when they choose to do it by a number of ingenious devices which maximise the disruption to the children at minimum cost to the teachers—and particularly deplorable when young children are exposed possibly to risks to safety in some individual cases; although we do not have an individual case being discussed at the moment.

22. In the coming Bill on education, would you consider making it a legal requirement to schools and employers that children be not sent home without at least one or two days' warning, written warning, to parents; so that in future we would not have this?

*(*Sir *Keith Joseph.)* I would have to consider such a proposal if it were made in the light of legal practicability. After all, it may well be—although it is for courts to decide—that what the teachers are now doing in many cases amounts to a breach of their contract. That is not for me to say. It is for their employers to consider whether they take disciplinary action and for courts to decide, if a case is brought before them, what the rights and wrongs are. But I could not accept Mr Greenway's suggestion without taking legal advice on its practicability.

Mr Callaghan

23. Thank you, Mr Chairman. Sir Keith, I should like to ask two questions. The first one is on conditions of service for teachers. I have tried to find the answer to the question that I am going to ask you by going to the 1944 Education Act and I am afraid that I have not been able to find the answer. I should like to ask whether you would like to comment upon and define—and the word mainly concerned is, "define"—the powers of the Secretary of State, namely, yourself, in comparison with the powers of the local education authorities, governors and heads of schools, as well as teachers, in light of the continuing dispute over the Poundswick graffiti case which, initially was concerned with the daubing of sexist and racialist graffiti on the walls of school buildings? Obviously, it is not the graffiti now which is the main issue but really the question of the definition of the powers of the various sectors in education. Would you like to comment on it and would you tell the Committee whether you have had any representation about the ending of such a dispute.

*(*Sir *Keith Joseph.)* The holder of my office has certain default powers and has some sort of quasi-judicial status in relation to their use. These default powers can be brought into question by complaint. Where a complaint has been made—and I think a complaint has been made about Poundswick—the holder of my office has to avoid making comments until he or she has all the evidence necessary to make a decision on the complaint before him or her. That is the state of affairs at the moment in relation to Poundswick.

24. And that is after three months?

*(*Sir *Keith Joseph.)* I think that that is so. I am not sure when the complaint reached us. May I turn to Mr Ulrich.

*(*Mr *Ulrich.)* The complaint came a lesser period than three months ago and what has been happening is that the Department, in accordance with the absolutely normal

[Mr Callaghan *Contd.*]

procedure, has been getting information from the local education authority on this extremely complicated story as to what has actually happened. It is now for the Secretary of State to decide whether, in accordance with the Act, he is satisified either that default has occurred on the part of the local education authority or that the local education authority is acting unreasonably in the statutory sense. And this turns on the facts.

*(*Sir *Keith Joseph.)* The word, "reasonable", has to be taken in its full legal sense as action that no—is it, "sensible"?

*(*Mr *Ulrich.)* It is action that no reasonable authority would contemplate or could be expected to carry out; not necessarily action with which one might disagree but action which is so arbitrary or capricious that no reasonable local education authority should take it.

25. You will appreciate that I am raising this question because it concerns not just Poundswick but the powers of the Secretary of State, governors and the local education authorities that have been brought into focus by this particular dispute?

*(*Sir *Keith Joseph.)* The answer to Mr Callaghan is, as I have stated, that the holder of my office does have default powers.

26. Thank you. May I now ask the second question, which is on teachers' pay? In this morning's "Guardian" John Fairhall has made the following comment. I do not necessarily agree with him but I think it is interesting. He said: "There is no shortage of concern. What we are looking for is effective action."——that is, in solving the dispute. "What makes teachers and many parents angry is not Sir Keith's lack of feeling" —— and again, I am not saying that——"but the ideological fixation, the intellectual arrogance, and the ill-informed political incompetence that have led the country's schools into an educational Passchendaele." That is rather a famous correspondent and that is what he has got to say about the dispute this morning. I should like to say that I do not think that things have been helped on the teachers' front by the Government, in July, accepting the recommendations of the Top Salaries Review Body to set pay rises of up to 46 per cent. I may quote as an example: 12.2 per cent for senior civil servants; 16.3 per cent for the Judiciary 17.6 per cent for senior military officers; 43.3 per cent for the head of the Civil Service—whose pay went up from £51,250 to £75,000, an increase of £23,000, almost two and a half times the average teacher's salary—and 31.9 per cent for admirals, generals, air chief marshals, whose pay rises fom £45,000 to £60,000; and I believe, Sir Keith, that you have been awarded an increase of £14,500 to raise your salary to £60,000, while you, yourself, restrict the teachers' increase of pay. One, could you justify that; and, two, would you not agree that the root of the dispute is that the ordinary teacher is just not paid enough?

*(*Sir *Keith Joseph.)* I am startled by the suggestion that I have received such an increase. I am not aware of it.

27. Then perhaps you can tell the Committee what you——?

*(*Sir *Keith Joseph.)* I think it is wrong. I think the quotation is wrong.

28. Then could you put us right?

*(*Sir *Keith Joseph.)* I shall certainly gladly comment on the Review Body recommendations which the Government accepted but I do not think that Mr Callaghan is right in confusing with them the pay of Cabinet Ministers. I really think that is quite wrong; and any suggestion of a £14,000 increase for Cabinet Ministers is, I think, totally out of——

29. Then could you tell us what it is, Sir Keith.

*(*Sir *Keith Joseph.)* As I remember, the House of Commons passed, against the advice of the Government, an increase of pay for Members of Parliament and Ministers, which certainly did not include a £14,000 increase for Cabinet Ministers—not nohow! But I want to come to the substance of Mr Callaghan's question to me; which is the acceptance by the Government of the recommendations of the Top Salaries Review Body—which did not include Cabinet Ministers. First, let me set the scene. The Review Body for Top Salaries has been advising governments of both parties. The 1978 recommendations of the Review Body were accepted by the then-Labour Government and were for far, far larger increases at the time, costing far, far more in aggregate, than were made on this occasion. On this occasion, the increases amounted in aggregate to about £10 million a year. Compare that, I must say to Mr Callaghan, with the £450 million extra offered by the Government to the world of education for the annual additional increase

[Mr Callaghan *Contd.*]

to salaries of teachers on a differentiated basis, and conditionally, under the offer made by the employers in their September 12th negotiations. The reason why the then-Labour Government in 1978 and the current Conservative Government in 1985 accepted the recommendations of the Review Body for Top Salaries was precisely the same as the reason that led the present Government to offer additional money, on condition, for teachers' pay: namely, the need to recruit, retain and motivate people of the right quality. And exactly the same analysis that led to the making of the recommendations by the Top Salary Review Body and that led to the Government's acceptance of those recommendations—namely, the need to recruit, retain and motivate people of the right quality for the Judiciary, the Civil Service and the Armed Forces—lay behind the offer by the Government of a continuing increase on top of all other increases of £450 million a year for the teachers. So I regard all this as part of the same Government attitude to pay in the public sector; namely, that it is necessary to fix the pay and career prospects at a level that will enable the employers to recruit, retain and motivate people of the right quality. I am being advised to qualify what I have said to emphasise that the £450 million conditionally additional pay comes into effect on the fourth year and will carry on thereafter.

Mr Thompson

30. Sir Keith, you did mention before—and we may disagree about the methodology—of people of the right quality not coming into teaching currently and of good teachers currently leaving the profession. I totally agree that this is happening. I think that you would also agree that the morale of the teaching profession is at absolutely rock bottom at the moment. In discussions that I have had with teachers recently, and particularly during the recess when I took the opportunity to talk to quite a number of teachers at all levels right through the whole of my area, I have found that it really is at rock bottom. The significant part of the problem of the present dispute is the pay. Another part of the problem that I find when I talk to teachers are the working conditions and the resources that they have. Is it not the case that if there were some indication of an improvement in both working conditions—the condition of the buildings in which they work—and of resources, along with the question of possible changes of conditions of pay, that you may then look to an improvement in the morale in the teaching profession and an opportunity for people of the right quality to come into it? Is that not all part of the resentment and the dissatisfaction in the profession now; and is that not part of the reason why they are involved in this dispute?

*(*Sir *Keith Joseph.)* I repeat that I do not think that any of that can justify the disruption of children's education. On the particular point about lack of resources, I have to accept that there are worries about the state of maintenance of many school buildings; there are worries about the adequacy of school libraries and of some equipment. Certainly, I accept that. But I ask Mr Thompson also to accept that many, though not all, local education authorities have chosen to spend some of the large sums of money they have from the public in ways that, for instance, HMI characterised as wasteful. If those many local education authorities chose to redeploy some of their money from the less priority educational areas such as cleaning, caretaking, school meals, into some of the more priority educational areas, a number of these grievances could be sharply diminished. But I also have to say that the lack of maintenance in many school buildings may go back over 15 or 20 years and cannot quickly be made up.

31. Chairman, may I take up a further point with Sir Keith. He did mention the question of cutting the expenditure on cleaning, caretaking and so on. Before I came to this House, I was a leader of a county council which, during the three years that I was there, examined almost daily the question of cleaning, catering and school meals because it is one of the areas which, I would imagine, one looks at first in terms of cutting expenditure on education. The cleaning element, certainly in the case of my authority, was cut down to the bare minimum, bearing in mind the need for hygiene. I should imagine that every authority in the country has done exactly that. The catering, too, after long negotiations and consultations, was cut to the minimum. School meals were necessary in many parts of my county because, in parts of the county, there was a rural aspect. Children were travelling, in some cases, 10 miles to school and 10 miles home. It was absolutely essential to have a school meals service through the middle of the day. I imagine that, by this stage, every authority in the country has examined those three elements

[Mr Thompson *Contd.*]

particularly and has taken them down to the bone; so that one has to look again, Sir Keith, at the question of how authorities are spending their money in terms of education. I think that almost every one of them has taken the matter as far as they possibly can. Surely, if you are talking about further reductions, you must look to areas such as music, children being able to move out of the school premises on visits and so on; you must look to that sort of area for further cuts. And I think that that would be even more damaging than the present teachers' dispute?

*(*Sir *Keith Joseph.)* I cannot comment on Mr Thompson's own experience. All that I can say is that the recent publications of the Audit Commission have asserted that there is scope for something like £50 million of economies a year in cleaning costs. I am aware of the relatively small amount—that the Audit Commission thinks could be increased, without unreasonable demands—of superficial yardage or metre-age that cleaners are expected to clean by many local education authorities. Mr Thompson will be aware that a number of local authorities with problems of rural sparsity, as well as urban authorities, have made substantial economies in school meals delivery and a large number of authorities refuse on policy grounds to copy them. So that there are savings to be made there. Moreover, the distinction between some local education authorities and others in the degree to which they propose closures of half-empty schools to the holder of my office varies quite sharply. So I do not accept that there is not scope in many local education authorities for redeployment towards educational priorities. I do accept that some of the more prudent authorities have very little scope. That is why the Government has introduced rate-capping, so as to try to reduce the over-spending of some authorities and to treat less harshly the prudent authorities.

Chairman

32. Secretary of State, most of our questioning has concentrated necessarily, and very properly, upon the financial aspects. What about progress, if any—or is there none?—on what I think is described in your statement of last August as: "A clear definition of the range of teachers' duties linked to their contracts of employment?" You set this out, as it were, as a draft, in a letter in the spring to Mr Merridale. Can you update us on where we stand on that matter; or, frankly, are we in limbo at the moment?

*(*Sir *Keith Joseph.)* The Government still adheres to its decision to make additional money for teachers' pay only available in return for the acceptance by teachers of the conditions broadly as set out in the letter to which you refer. Those conditions reproduce the normal conditions which teachers over the decades have accepted and implemented, plus appraisal but minus midday supervision. The employers embodied that condition in their offer of 12 September. The offer was rejected. The employers by a majority vote decided to offer a no-strings settlement for 1985 and that particular offer is still, I suppose, in one form or another, on the table. I say, "in one form or another", turning to Mr Halsey, because I cannot precisely recall at what level it stands.

*(*Mr *Halsey.)* There was an informal offer made at the last meeting of the committee, Chairman. I think, therefore, since that was not accepted, that the formal position is that it reverts to the offer made earlier in the year by the local authorities. But that also was in terms of pay only.

33. But do we correctly understand that that offer is attached, if I may so express it, if not to use the word, "conditional", upon the acceptance of the statement of duties to which we have just been referring?

*(*Mr *Halsey.)* As I have just said, Chairman, the local authorities have been seeking for a long period to engage in negotiations leading towards a clearer definition of teacher duties broadly along the same lines as the exposition set out in the Secretary of State's offer. But progress towards that during this year's negotiations has not so far been successful and the offers which the management side have most recently been making to the teachers have been in terms of pay alone.

34. While we are on just this point, could you, Secretary of State, assist us by charting the dates ahead? I do not mean the exact dates, but the moves ahead. You will have understood, and you have shared, the anxiety of the present position which no-one, from whatever view they look at these matters, can regard as satisfactory, you, yourself, very much included. What is the next move? Is it the getting together once again of the teachers' panel? Is that the thing which must trigger the next moves before the Burnham Committee meets?

*(*Sir *Keith Joseph.)* I cannot give a firm answer but my understanding is that the

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teachers—and, of course, I cannot commit them to this—are planning a meeting of the teachers' panel on 5 December, I am told. Out of such a meeting, or from the initiative of the employers' panel, a full meeting of Burnham might occur. But I cannot predict that.

Sir Gerard Vaughan

35. Secretary of State, in your package —as I understand it—some teachers will receive a 24 per cent increase. Is that correct? What will that be in actual cash?

*(*Sir *Keith Joseph.)* I think that the 24 per cent would probably be for heads and might be as much as £4,000 a year. But may I turn to Mr Halsey for the details here?

*(*Mr *Halsey.)* Chairman, the offer that was made by the employers is a complex offer with a large number of different figures in it. I do not have the complete details with me. I think that it would be better for us to send the Committee the full details if they would like to have them.[1]

*(*Sir *Keith Joseph.)* I must repeat, Chairman, that the offer of additional money is over and above the annual pay award that the teachers negotiate.

36. Would you care, Secretary of State, to comment on Mr Jarvis's statement that 150,000 teachers will receive virtually nothing?

*(*Sir *Keith Joseph.)* Something like that is true. One-third of teachers will receive substantial increases over and above the normal annual increase; one-third would receive significant increases above the normal annual increase; and about one-third of teachers would receive no particular addition from the offer made by the employers. Those would tend to be teachers on their way either to re-training, in-service training, or to future possibilities of promotion; because the offer contained 70,000 extra promotions.

Mr Greenway

37. I think, Secretary of State, that you said that the one-third who would receive virtually nothing, apart from the annual rise, would have other prospects. Would that be so?

*(*Sir *Keith Joseph.)* They would have better prospects because the career profile for teachers would have been sharply transformed had the offer been accepted.

*(*Mr *Halsey.)* May I add a small point to that? A large number of those teachers who are described in that way would be at present on Scale 1 and, in the slightly longer term, the proposals envisage the merger of Scale 1 and Scale 2; so they would progress to a higher salary than is currently assured to them.

*(*Sir *Keith Joseph.)* The Scale 1 and 2 merged salary would have a maximum £2,000 above the present maximum of those scales, in addition to the annual increase.

38. But they would be receiving an extra £2,000 a year ultimately. Is that what you have just said?

*(*Sir *Keith Joseph.)* I have said that there would be that prospect of a maximum ahead of them.

Mr Flannery

39. Why do they not accept it, Sir Keith, if it is so lyrically beautiful?

*(*Sir *Keith Joseph.)* I hesitate to give an answer that I know will cause some disagreement but I do find that quite a number of the teachers to whom I talk are rather hazy about what the offer might have meant for them. To some extent, this is understandable because, as Mr Halsey says, the offer covers nine pages; and no teacher can be absolutely sure that he or she, for instance, will benefit from one of the 70,000 extra promotions. Nevertheless, the extra money does make a significant change to the salary and career prospects of teachers. The fact that it was rejected so sharply by teacher unions and that words of outrage were articulated by teacher union leaders may have coloured the reaction of many teachers to the offer as it might affect them. I know from one local education authority that the reaction to their publication of the offer was to indicate that quite a substantial minority of teachers found the offer acceptable, quite a substantial minority of teachers rejected it and the remaining one-third substantial minority were interested in discovering more about it. That is not quite the same picture as has been widely published.

Chairman

40. I think that we ought to move on if we are to cover all the subjects. We have obviously spent time on that one because it is a very important and highly topical matter, I think that, if we may, it would be helpful to us to take up Mr Halsey's offer; that would be of assistance to us. Let us move on, then, if we may, to preparation for the GCSE. Perhaps I can set the ball rolling here, Secretary of

[1]See Annex p 19.

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State. We have seen your various published statements, including that which covers the distinction and merit certificates, in respect of which—as we understand—you have further consultation in hand. Do you feel that the LEAs will, in fact, be able to make effective preparation for the introduction in 1988; or is that programme likely to slip?

(Sir Keith Joseph.) The programme will not slip. The local education authorities can make the preparations. We are at the moment on timetable.

41. What about the merit and distinction awards? There, you have further consultation in hand. Is that the position?

(Sir Keith Joseph.) It is the results of the consultation which we are studying.

(Mr Ulrich.) The position is, Chairman, that we have all the replies that I think we are likely to get on the document to which you have referred. The Secretary of State has said that in the light of these replies, he proposes to issue for consultation a somewhat revised scheme and it will be inevitable that, as a result of that further stage, merit and distinction certificates cannot be introduced, as had originally been hoped, at the same time as the new GCSE is introduced. The introduction will have to be later.

42. And it is possible—and after this question I must pass the mike—at this early stage to forecast how much longer after 1988 those certificates might be seen? Or is that at this stage really beyond foreseeing?

(Mr Ulrich.) I think that it would be very unwise to speculate.

Mr Flannery

43. At a recent meeting, Secretary of State, AMA passed a resolution asking you to postpone the introduction of the exam for a couple of years. They put forward in their debate all kinds of considerations, in-service training; that it would need, for instance, a far greater number—and this would be expensive—of supply teachers to take the places of the teachers who were in training. They put forward a variety of reasons, very practical reasons, for a delay of a couple of years. It was moved by somebody that there should be a delay of one year; but that did not get anywhere at all. I wonder if you could comment on this?

(Sir Keith Joseph.) As I remember, the local education authorities were claiming that it was going to be very hard for them to play their part in the necessary preparation because of lack of money. As a result of the representations—including those to which Mr Flannery refers, I announced that the Government had decided to increase from 70 per cent to 90 per cent the contribution that would be made to local education authorities' preparatory costs and that they would inject a further £2 million towards the costs of one of the stages of the preparation. I understand that those two initiatives by the Government have been welcomed.

Mr Callaghan

44. With regard to the in-service training, how many teachers would that involve?

(Sir Keith Joseph.) That is very much local education authority business. It is not, as it were, a central government decision. The sequence of events for the preparation is that subject leaders are being given in-service training—and it is relatively brief—starting in January. And, once subject leaders have had that in-service training, they will then pass on what they have learned to the general body of teachers who will be teaching GCSE; so that I cannot give specific numbers.

Mr Greenway

45. I have been looking at several of the new syllabi for subjects in GCSE and a number of local authorities have said that they do not think they will have the money to provide all the new textbooks and materials that will be required by pupils. Do you think that they have any legitimate grounds for those fears?

(Sir Keith Joseph.) I think that there are shortages of textbooks in general in some schools but that the worry is not particularly associated with GCSE. GCSE will not, in itself, require the wholesale replacement of textbooks. I wonder if I might ask Mr Ulrich to supplement that?

(Mr Ulrich.) Chairman, only to say that I think what is most likely to be required will be some supplementation to existing textbooks rather than a wholesale replacement. If existing textbooks were found to be adequate for O-levels or CSE, they ought to form a very good basis for the GCSE but they may need to be supplemented.

46. May I put a quick question on the merit and distinction certificates which emanated from the Select Committee of the last Parliament? On an all-party basis, I may say, we suggested a merit group certificate

[Mr Greenway *Contd.*]

on the basis of those pupils who could attain an O-level in A to C grades in five reasonably spread subjects. As a Committee, we did not envisage the sort of distinction certificate which has emerged from your Department nor even anything as rigorous as a merit award. Is it possible to have, say, a distinction certificate—which may be tough— but, certainly, some closer thinking to the original recommendation of this Committee which was based upon a wish to see thousands and thousands of children achieve five O-levels who currently only achieve one, two or even none at all—but who, we thought, could do much better with that sort of incentive?

*(*Sir *Keith Joseph.)* Certainly, we shall have that purpose—which, as Mr Greenway says, stemmed from this Committee—very much in mind in considering the results of the consultation. There are other factors working towards the breadth and quality of examination results other than distinction and merit certificate ideas. There is the whole pressure towards the breadth in the curriculum for all children and the attempt, through GCSE, to bring into examinations through differential criteria a far wider proportion of children than have so far tried to get more than perhaps one CSE or one O-level. In addition, there is, of course, the AS broadening initiative. So, yes, certainly, we can take into account that which Mr Greenway mentions in the reconsideration now going on.

Mr Sims

47. Sir Keith, why do you feel that this target date is so important? You say that you are on timetable at the moment but you will be aware that these sorts of timetables can slip even in the best of conditions; and at the moment all is not well on the schools front. You will also be aware, I am sure, that a number of headmasters and headmistresses are concerned as to whether they are going to be able satisfactorily to introduce the new system properly by the target date. Would there not be merit in ensuring that the thing starts properly and is properly organised by deferring it for a year; rather than risk it coming in, as it were, at half-cock on the target date?

*(*Sir *Keith Joseph.)* I do not accept that it will come in at half-cock, Mr Chairman. Moreover, I have to tell Mr Sims that the enthusiasm, the ardour, for a new examination, for a new system of examinations, was very strong indeed; and that the decision made by the Government to bring in the GCSE was very widely welcomed by teachers. I, therefore, see no reason for; in fact, every reason against, deferring it.

Mr Thompson

48. Following the answers to the questions that have been put to you on this point, can we assume that you are not anticipating any problems from the teachers' dispute affecting the timetable of the GCSE?

*(*Sir *Keith Joseph.)* I am not contemplating any deferment of the introduction of the GCSE.

49. Can we then assume that you are anticipating a fairly early ending of the teachers' dispute?

*(*Sir *Keith Joseph.)* No-one can be sure about that, Chairman. It is open to the teachers' unions to end the disruption at any moment. I constantly hope that they will.

50. Chairman, may I follow that through because it is important? If the teachers' dispute continues into next year when the programme for in-service training begins, there is a likelihood of that affecting the in-service training programme, surely?

*(*Sir *Keith Joseph.)* I would find it very hard to believe that teachers who were so keen to have a new system of examination introduced and so welcomed the Government's decision would interfere with the examination and damage still further the education of children. I find that very hard to believe.

Chairman

51. This is an important sector but, perhaps, we ought to move on. Secretary of State, it occurs to me that you might like to have a glass of that colourless liquid in front of you. You have been sitting there answering questions for rather a long time. That sort of strain or perhaps a little dust in one's throat can be very irritating. May we then move to teacher supply? Secretary of State, you took us into your confidence at an earlier stage in identifying as one of the factors which had led the Government to suggest that the employers should make a very different structure of offer, I think I heard you correctly, the falling away of the numbers of good entrants into the profession offering themselves for training. Could you develop that a little and share your anxieties on that score with the Committee?

*(*Sir *Keith Joseph.)* Gladly. I should like Mr Halsey to supplement what I say. I

[Chairman *Contd.*]

understand that up till about two years ago there was really an abundance of candidates pressing for admission to teacher training institutions, candidates, many of whom were of adequate quality. I believe the position is now that instead of an abundance there is an adequacy of candidates. May I turn to Mr Halsey? That is right, is it not?

*(*Mr *Halsey.)* The position varies substantially, Chairman, according to the kind of training. Despite, for example, the need and the decision of the Secretary of State to increase the entry to primary training in line with the end of the decline in primary schools rolls, the primary training places overall are still well filled with applicants. The shortfall in entrants to training courses still concentrates on the traditional difficult areas but has worsened during the last couple of years. Even in the fields of training for secondary teaching in CDT, mathematics and physics, two or three years ago the position had improved and was relatively good. But the entry to courses since that time has declined and the figures now are substantially below the target figures set by the Secretary of State for entry to courses.

52. I am sure that my colleagues will want to follow up different aspects of this, so that perhaps I may confine myself to only one. You know, Secretary of State, that this Committee is engaged in a careful look at primary—the education of the youngest child. If I have understood your thinking correctly as expressed publicly, you are hoping that the increased numbers coming into the teaching of the youngest child—which, fortunately, Mr Halsey has been able to tell us is on target, as it were; and I hope that that is right. Oh! I have got something wrong there, have I?

*(*Mr *Halsey.)* No, Chairman. I spoke of entry to primary training courses. It is possible to break that down further. I explained that the situation varies, according to the precise group one looks at, into those training within primary for the early years of schooling and those for the later years of primary schooling. The position is relatively good in relation to the later years of primary education. It is, we think sufficient but rather tighter in relation to the earlier years of primary education.

53. That, too, it is very helpful to have drawn out in the light of many discussions and visits which this Committee has paid, not only in this country. While being grateful for that assistance, may I still ask the Secretary of State this question. As I understand his public view, it is to express the hope that this number will not be used to make fractional differences in size of class but will do other work—the support of other teachers, and so on. How does the Secretary of State expect the holder of his office to secure this, since teachers are employed by the LEAs; or will he rely solely upon an expression of view and an expression of hope on his part. I do not want to make it sound discourteous, but has he got any teeth in this respect?

*(*Sir *Keith Joseph.)* No. But the discussions on technical matters with the local authority associations are fairly continuous and I think there is a certain amount of agreement that the criterion of progress is not just the size of classes; that it should be open to the heads to deploy their teachers in what they think is the most helpful manner for the children. And, indeed, closely related to that is the pressure that local education authorities feel upon themselves to move to take out surplus places so as to deploy their teachers in the most effective way. I often find incredulity when I say to teachers that the pupil-teacher ratio is at record low levels—that is, satisfactory levels—and that the spend per child is at record high levels in real terms. The reason why these trends are not manifest to many teachers is that some teachers are not being fully used, are teaching in half-empty schools; so, although I do not have "teeth", I believe it common ground with the local education authorities that the criterion of progress should not just be merely class sizes. But I have to add that the Government accepts that some extra non-contact time should be regarded as the norm for primary school teachers. They are too closely tied to the classroom at the moment. Therefore, the Government accepts that some additional primary teachers, over and above what would otherwise have been necessary over the years ahead, should be built in so as to increase the non-contact time of primary school teachers.

*(*Mr *Halsey.)* I would only add to that, Chairman, if I might, that the Secretary of State agreed with the local authority associations earlier this year that there should be a joint working party of officials looking at some of these issues, and considering whether further work would indicate that some guidance might be issued

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to local authorities generally in relation to the numbers of teachers and deployment of teachers, including things like contact time and class sizes. And that work is going ahead on a joint basis.

Mr Flannery

54. When, Sir Keith, you said at the local education authorities' conference this year that 15,000 more teachers will be needed in primary schools above the number required to maintain pupil-teacher ratios, do you still hold to that? Is that what you were talking about a minute or two ago?

*(*Sir *Keith Joseph.)* Yes.

55. So that is a fact?

*(*Sir *Keith Joseph.)* Yes. We accept that over the years we should finance an increase of that order.

56. May I then ask you, and Mr Halsey, something pursuing what Mr Halsey has already said? Our advice—it is oral at this stage but it comes from reputable places; from inspectors, local inspectors, heads and so on—is that it is very difficult indeed to recruit teachers for, for instance, nursery classes in schools and that it is becoming difficult to recruit suitably trained and experienced teachers for infants, especially reception classes; and that there is some difficulty in getting people into the colleges for primary BEd courses. Is this your experience, Mr Halsey?

*(*Mr *Halsey.)* As I indicated earlier, the position in relation to entry into training courses for the earlier years—and I include within that the nursery class end of the primary spectrum—is tighter than in the later years of primary education. But the present indications are that the number of places provided for primary teacher training overall can be expected to be filled, and from a larger number of applicants than is required to fill them overall. Within that, the proportion taking courses aimed at the earlier years of primary education is not, as it were, set by the Secretary of State; we are engaging in discussions with providing institutions to encourage an increase at that end of the spectrum. And we believe that we shall see an increase at that end of the spectrum matching the needs as the next year or two goes by. I accept that it is tighter at that end. I do not think that the supply at the moment is inadequate.

57. If I may follow that up, Chairman. You mentioned, Mr Halsey, that there is probably a working party to be set up and that they are going to produce—CLEA is, anyway—a document on this. To what would you attribute this difficulty in getting teachers at this lower end at a time like this when there is so much unemployment? What would be the reason, do you think? I know that you cannot necessarily have it at your finger tips. But there must be some reason?

*(*Mr *Halsey.)* The working party, Chairman, to which I referred just now is looking at the need for teachers in the schools in number terms over a period of years to meet intended improvements in the curriculum and so on, as set out in the White Paper, "Better Schools". It is not a working party looking at the entry to teacher training. That is just to be clear on that point. I think that it is not easy for me and perhaps not easy for others to say why precisely there may be a smaller demand for places in teacher training for one age group rather than another. I think that it is relatively easy to see that there is a change in the demand in the schools as time goes by because of the change in numbers of pupils of different ages. I believe it to have been the position over recent years that much of the demand has been at the upper end of the primary schools and now, because of changes in the birth rate, there is an increase in numbers of pupils at the early end of primary education which has increased the demand for teachers trained for that phase which has needed a change in the balance within the training institutions. As I say, although I believe the position is relatively tight at that end, I do not think that there is evidence of a failure in supply.

58. You would not think, for instance—and this is my last question, Chairman—that it might be that teachers at that level of teaching are basically Scale 1 and Scale 2, that their pay is pitiful and their hope of any prospects of moving from their scales is very remote?

*(*Sir *Keith Joseph.)* I think I had better take up the answering here because I want to quarrel with this word, "pitiful". As I gather, the position is that the entry pay for teachers, the entry pay, is not all that far apart from the entry pay for many other careers. The problem about teachers' pay is one for more mature teachers. The offer that the Government has made conditionally would fairly sharply improve the career prospects—both in promotion, in-service training and pay—for teachers who are

[Mr Flannery *Contd.*]

beyond probation, leaving the entry pay comparable, broadly, with many other careers. So that I do not think that that is really a factor. Maybe the ill-repute that the dispute has brought upon teaching, to some extent, may have discouraged some from entering.

Mr Callaghan

59. Sir Keith, as you are aware, I have led a lobby for several years in the hope that we could convince you to allow the De La Salle Catholic teacher training college, which is situated in my constituency, to remain open. In the light of the recent visit of the Under-Secretary to the college and in the light of the statements that we have heard this morning that there is now an increase in the birthrate and that younger children are coming into schools, do you offer any hope for the continuation of the De La Salle College in my constituency?

(Sir Keith Joseph.) The decision about teacher training at De La Salle has, I think, been made. The question now is about the future intake for its diversified courses. That decision still has to be made. I have at the moment a recommendation from NAB, do I not?

(Mr Bird.) It is the recommendation of the NAB for closure which is still being considered within the Department.

(Sir Keith Joseph.) But the teacher training issue, I think, is off the agenda.

60. When was that decision made?

(Sir Keith Joseph.) A couple of years ago, was it not? Nothing new has emerged this morning about that. Would Mr Callaghan like me to remind him of the dates concerned?

61. Yes, please. I do not know them?

(Sir Keith Joseph.) I am startled. Nothing new this morning was meant to be announced. I have nothing new to say.

Chairman

62. Well, thank you very much, Secretary of State, on that. We now have a few minutes in which we can raise some topical matters. But I think it might also be helpful if we could say a word about the Autumn statement and all that flows from that. I am thinking of the extra 5,000 places in engineering and technology in higher education, the new phase of the "switch". Is there any ground for anxiety that there will not be available the necessary expertise for teaching this extra cohort?

(Sir Keith Joseph.) No, I think that the most careful preparations were made to ensure that the teachers, the equipment and the industrial support were all available to the institutions which received allocations of money for this switch. I think, more than ever before, we asked to be assured that the institutions that were bidding for the extra places and the extra finance commanded industrial approval and industrial support in the sense of help with teaching, help with equipment, help with placements. And, on that assurance—and only on that assurance— were the allocations made.

(Mr Bird.) May I add a few words merely to say that we are monitoring the truth of the assertions and fully expect shortly to have corroboration of the ability of institutions to show industrial support.

(Sir Keith Joseph.) No allocations were made to institutions unless they were able to show that their courses, their teaching skills and their equipment were, with the help of the employers concerned, up to the very high quality requirements specified.

63. You will know, secondly, arising out of the Autumn statement that this Committee watched with particular interest your increased allocation on the science budget. It is £15 million, is it not? Perhaps since you do not often get people saying, "Thank you" to you, this Committee might do that on this occasion. I would express the gentle hope that you would also look favourably on the other detailed recommendations of this Committee in the same report?

(Sir Keith Joseph.) I shall try to do so, Chairman; but I should like to thank you for what you have said but to remind the Committee that, in addition to the extra for the research councils—which corresponded exactly with the research councils' request for £15 million for the first year; though fell short of the extra that they requested for the second and third years—extra money has been found to accelerate the modernisation of the equipment of selected parts of the university laboratories.

Sir Gerard Vaughan

64. These changes are very welcome, indeed. What is your feeling about the general financial position for the research councils in the future? Do you think that perhaps a new system of funding is going to be necessary for them?

[Sir Gerard Vaughan *Contd.*]

*(*Sir *Keith Joseph.)* The Government understands the acceleration of opportunities for basic scientific research. The opportunities are accelerating as almost never before. Therefore, the Government has taken on board the need for the research councils and the case they are making for more finance—a case that the Government has entirely met for the first year of the three years ahead but only partly met for the second and third years. We are also conscious that a brain drain has been intensified and we very much hope that the extra that has been provided this year, the prospect of extra for the next three years and the accelerated modernisation of selected university laboratories will stem the brain drain. So the Government has taken on board thoroughly the bid by the science community and will do its best, other constraints permitting, to make possible even more effective scientific research than we enjoy now.

65. There are expenses over which the research councils really have no control, for example, international subscriptions and things of that sort. It was one of the recommendations in a paper from the Committee that the Government should look at some other way of funding these?

*(*Sir *Keith Joseph.)* Yes, indeed. And we take that recommendation seriously. Minor modifications to the advantage of the science community have been agreed with the Treasury but any total redeployment of responsibility has not yet been agreed; nor can I hold out much prospect of that in the near future. It is to take into account the drain upon the science budget of these responsibilities to which Sir Gerard referred that we have increased the provision for basic research.

Mr Callaghan

66. Sir Keith, in the recent HMI report on LEA expenditure, the HMI themselves were highly critical of the repair and maintenance of school buildings. In my own constituency, in the last year, four schools have had to close because of falling plaster from the roofs. I am told that one of the schools, in particular, Elm Street, needs £600,000 spending on it to bring it up to proper standards. Is there anything in the Government's expenditure programme to improve school buildings? And, of the £294 million capital expenditure, how much is available for the repair and decoration of schools?

*(*Sir *Keith Joseph.)* It is an unsatisfactory position, Chairman, because we are dealing here with a backlog often stemming from very many years of inadequate maintenance. But I have to tell the Committee that it is not possible to measure what is going to be spent on schools entirely from the allocation which was published with the Autumn Statement. Education authorities do retain a power, limited to some extent, to spend their own money; both to spend from the proceeds of sales, and to "vire" from other departments where they are multi-purpose authorities, in favour of school maintenance and repairs if they so wish. I am not pretending that that totally answers Mr Callaghan's worry. But it is something that should prevent us from merely judging by the published allocation in the Autumn Statement.

Mr Flannery

67. We have recently received correspondence from NATFHE, many of whose members teach, as you know, in polytechnics. In part of the recent letter it says: "Public Sector higher education"—which is polytechnics, basically—"is facing a severe financial crisis in the year 1986–87." It goes on to say: ". . . if a comparison is made with spending on the other side of the Binary Line,"—compared with the universities—"it is difficult to escape the conclusion that students in our sector are being educated on the cheap. In common with almost every member of the NAB Board"—and these are the writer's words—"I regard this position as inequitable and ultimately as financially inefficient." I have spoken to various polytechnic principals recently—I do not know whether my colleagues have done so—and that embodies their general thinking. It is something which is a constant topic of conversation in poly staff-rooms. I wonder if you would be kind enough to comment on it?

*(*Sir *Keith Joseph.)* I do not accept that you can judge the effectiveness of polytechnics and colleges simply by comparing the monies spent on them. They are doing a very good job. They do not have the same specification or coverage as universities where, for instance, the medical schools and the veterinary schools are concentrated. They do not have the research obligations to the same extent that universities do. This must alter the comparison of budgets. Mr Flannery touches upon an area of constant argument—the exact measurement of comparative costs. I accept that there

[Mr Flannery *Contd.*]

is some anxiety about it. But, from the Government's point of view, the polytechnics and the colleges are being adequately financed for the very good job that, in general, they are doing.

68. So that you do not think that they have any reason for complaint. They are complaining quite volubly, everywhere, about it. But you say that there is no reason for it?

*(*Sir *Keith Joseph.)* I say that the bringing together of the costs of universities, on the one hand, and the public sector higher education, on the other, is not, in itself, to my mind, a purpose; because they have different functions and characteristics. What is, I think, to be admired is the way that the polytechnics and colleges have increased their productivity. They have increased the effectiveness of their lecturer force by moving nearer towards, or actually at, a 12:1 staff-student ratio, which is very commendable; but there is no reason to think that that has led to any decline in the quality of the output.

Chairman: I think it might be helpful if we could conclude, Secretary of State, with a few purely topical matters. I think that the Committee finds that helpful and I think, Mr Greenway, that you have the first one.

Mr Greenway

69. May I refer to two points, Secretary of State, first, to freedom of speech in the universities but, before I come to that, ask you to comment on the centre-page spread of the "ILEA Contact" of 22 November 1985, in which it says to the reader: "A positive equal opportunities policy is one of the strengths of the ILEA. On these pages, staff from adult education and the youth service show how their sectors are responding to the commitment." Then, in heavy type, an article entitled, "Young lesbian groups". It reads: "Young lesbian groups are open to young women aged 16 to 21 who are lesbians, or think they might be." Then it goes on and I pick it up where it says: "Groups help members to maintain communication with family and friends, to get advice, information and counselling on personal and many other matters, such as housing, training and jobs. Young lesbian groups give young women a space to look at their own sexual orientation, whether they decide they are lesbian or heterosexual, without prejudgment." And so it goes on: "Currently the Authority's Youth Service supports young lesbian groups and gay youth groups in seven of the inner London boroughs." Do you think that that is a helpful situation? Or do you share my concern that young people who are basically not inclined to be lesbian or homosexual might be drawn into these groups and undermined? And is it, in fact the way to spend ratepayers' money? I think that Sir Gerard Vaughan wants to make a medical comment. We have discussed it?

*(*Sir *Keith Joseph.)* I should be grateful if Mr Greenway could repeat his question so that I know whether the answer I want to give should be in the positive or affirmative. He switched from—

70. Is that a suitable expenditure of taxpayers' and ratepayers' money and does it represent—?

*(*Sir *Keith Joseph.)* May I answer one question at a time, Chairman? In my view, no.

71. Secondly, is it a danger or otherwise to young people?

Sir Gerard Vaughan

72. May I come in there, Chairman and put the question to the Secretary of State? Is it not medically likely to be very harmful for some young people? It is quite normal for young people to go through a period of uncertainly as to whether they are heterosexual or homosexual or lesbian. If at that time they get drawn in, with public funds, into an organisation like this, it could be positively damaging to them?

*(*Sir *Keith Joseph.)* It seems to me that I would be wise to accept a doctor's advice on that!

Mr Flannery

73. It is a random question but I shall mention it, if I may. Whatever else will be in the Press tomorrow, that should feature more than likely in the Sun. But I want to move on to something else. The question that I want to move on to is this. All MPs are getting letters from the architectural departments of various colleges. I am wondering if you could help us on this. Perhaps I might read out the first paragraph of the most recent one: "I am writing to you as a Member of the Select Committee on Education about the economic implications of the proposal by the National Advisory Body for Higher Education—The NAB—to restrict entry to the architectural profession

[Mr Flannery *Contd.*]

by merging or closing up to ten architecture schools." We have received letters from individual schools. I have received them from Huddersfield, for instance. I wonder if you would be kind enough to explain to us whether this is just a cut to save money or whether there is any good reason for it; because architects up and down the country are now deeply worried, according to the amount of correspondence we are getting?

*(*Sir *Keith Joseph.)* I understand that I am due to receive from NAB some advice on the architectural schools where, it is said, there is a considerable over-supply of architectural graduates. I do not know whether Mr Flannery has seen a recently published report by HMI on the number of architectural departments in the polytechnic sector. Perhaps I may ask Mr Bird to come in on this.

*(*Mr *Bird.)* I think that this is quite a long-running saga, stemming, indeed, from concern over over-production of architecture graduates—and, of course, they are expensive courses. The activity has been undertaken on a trans-binary basis involving the UGC, the NAB and the Scottish Education Department which funds central institutions in Scotland. Proposals came from that process which are to be considered by those bodies. For its part, the UGC has not yet formally considered the part of the report which concerns it, although there has been a good deal of discussion about the school in Belfast. The National Advisory Body has taken the recommendations at Board level, as was published in last week's educational press. As I understand it, the NAB committee will receive the recommendations of the Board at their meeting next Monday and may be expected then to advise the Secretary of State.

74. So that no decision has been taken at this point?

*(*Mr *Bird.)* No.

Chairman: I think, Mr Greenway, you had a second question.

Mr Greenway

75. I shall be as brief as I can but, Secretary of State, it is a very important issue: freedom of speech in universities and institutions of further and higher education; indeed, in all institutions of education beyond. The Minister of State at the Home Office, David Waddington, was recently prevented from speaking at Manchester University and punched and spat upon. You, yourself, I believe, have been subjected to eggs and the like; but you have managed to speak. In various institutions of further and higher education there is growing evidence of people who have a view to put which is accepted before the law and not illegal but who have been prevented from putting that view. What can be done? And can you make any comment as to what you think the Vice-Chancellors might do?

*(*Sir *Keith Joseph.)* I think that freedom of speech is a vital element in our way of life in this country—freedom of speech within the law. And, not least, of course, in institutions of higher education. I was, as I imagine were most people, horrified at the treatment that the Minister of State at the Home Office received when he visited Manchester University. I am totally satisfied that the Vice-Chancellor of Manchester University has taken the incident intensely seriously. The processes of inquiry are for the University and the consequences of any inquiry are entirely for the University. We must wait and see what those processes of inquiry that have been put in hand yield. So far as the Vice-Chancellors are concerned, I am totally satisfied that they, too, have the problem on board. They are considering what advice to give to their brethren among the Vice-Chancellors and we await that. My worry, Chairman, is that we are reading only of the overt effect of barbarism of the sort that erupted when Mr Waddington visited Manchester University and that we do not see, because it is censored, the reception that opinions that might be unpopular in some universities would receive if the people who held them were, in fact, invited to come to universities. There is, as it were, a filter operating under which certain people who hold perfectly legal opinions are not invited to many university campuses, simply because it is thought that a very small minority would create trouble if they were invited. That seems to me to be something that the Vice-Chancellors and we should take very, very seriously into account.

76. And where these violators of human freedom, as they are in your description, can be traced—as they could at Manchester, for example—would you say that they should be sent down from the university; or would you say that they should simply be reproved and given further opportunities to study? How rigorous need sanctions be to clear up this very serious violation of human freedom?

*(*Sir *Keith Joseph.)* That is for the Vice-Chancellors to decide. I must leave it to them.

[Mr Greenway *Contd.*]

77. But do you have a view?

*(*Sir *Keith Joseph.)* I am tempted to give a view but it is for the Vice-Chancellors to decide; and I am sure that they take the subject intensely seriously. I am worried that people whose views are unacceptable to a small minority are no longer being allowed to be invited to many—well, I cannot say "many"; but to some—universities. And that is a very serious infringement of that toleration and freedom of speech which should exist all over the country and, particularly, in universities.

78. And are not such students damaging their own institutions, as well—those institutions to which they, themselves, belong?

*(*Sir *Keith Joseph.)* They are certainly seriously damaging the name, not only of their own institutions but the whole group of institutions of higher education.

Chairman

79. That seems an appropriate note on which to end because, happily, at least in this room, Secretary of State, we can all express different views and act as we like. May we thank you warmly for coming today? May we wish you a Happy Christmas, as we shall not see you before then officially, and may we wish you a trouble-free New Year?

*(*Sir *Keith Joseph.)* Thank you very much, Chairman.

ANNEX

Letter from the Secretary of State for Education and Science to the Chairman of the Committee

At the meeting of the Education, Science and Arts Committee on 26 November, you said you thought it would be helpful for the Committee to receive full details of the offer which the Management Panel made in the Burnham Committee on 12 September. The offer was constructed on the basis of the Government's conditional willingness to see an additional £1,250 million spent on teachers' pay in the years 1986–87 to 1989–90. The offer was rejected by the teachers' unions after 20 minutes' consideration, and it has not been reinstated although the Government remains willing to see the additional resources spent on teachers' pay if its conditions are satisfied.

I enclose the offer in the form it was presented by the Management Panel. As I said on 26 November it runs to nine pages. The Committee therefore may also find it useful to refer to the summary of the offer which I gave in an answer to a question from Jim Pawsey on 28 October (Official Report, Col 299–300).

Members of the Committee will also be aware from my answer to a question from Harry Greenway on 8 November (Official Report, Col 11–12) that the resources proposed for midday supervision, of up to £10 million in 1985–86 and £40 million in 1986–87, would fall within the £1,250 million.

10 *January* 1986

Management Panel Proposals for Improved Pay and Career Structure

1. The Management Panel submits the following set of proposals in an earnest attempt to resolve the current dispute in the interests of the profession itself, local education authorities and, not least, pupils and parents.

2. The Secretary of State's conditional offer to release additional resources of £200 million in 1986–87 rising to £450 million by 1989–90 has made it possible to put forward new proposals, but financial constraints continue to mean that the improvements we are offering will need to be phased over a period.

3. The Secretary of State's proposal to increase the total of LEA expenditure on which rate support grant would be paid in 1986–87 is dependent upon satisfactory progress being achieved by 11 October towards an agreement which meets the Government's objectives. The Management Panel feel that it is essential that this offer is grasped so that additional money can find its way into teachers' pockets next year and that the opportunity can be taken of improving career structure and promotion prospects of teachers.

4. The proposals now put forward therefore form a total package which needs to be considered as a whole.

CURRENT SALARIES

5. The first stage in the Management Panel's package is for an offer as follows:

	Paybill		*Increase for Individual Teacher*	
	Cost 1985–86	*Cost 1986–87*	*Highest*	*Lowest*
(i) *From 1 April 1985* an increase of £480 or 5 per cent on all scale points and allowances (except London and Social Priority Allowances)	5.43%	5.43%	8.82%	5.00%
(ii) *From 1 September 1985* the merger of Scale 1 and 2 on the understanding that the scale 1 teachers would be expected to undertake the duties of teachers currently on scale 2	—	—	4.09%	3.65%
(iii) *From 1 November 1985* a further 1 per cent increase (on the base) on all salary points	0.42%	1.00%	1.00%	1.00%
	5.85%	6.43%		
(iv) *From 31 March 1986* all teachers on their salary maximum to receive an additional increment. (Teachers on scale 1 will benefit from the merger of scales 1/2 and will not be affected.)	—	1.65%	4.90%	3.40%
TOTAL	5.85%	8.08%		

6. Clearly, the cost of the additional increment takes up part of the additional resources for 1986–87 earmarked by the Secretary of State.

MIDDAY SUPERVISION

7. An additional call on these resources from 1986–87 is to deal with the supervision of pupils during the midday break. The Management Panel has asked the local authority associations to consider a scheme to enhance the support available to headteachers during the midday break. This will involve payments to teachers, or others, undertaking these duties on separate contracts.

IMPROVEMENTS IN THE CAREER STRUCTURE AND PROMOTION PROSPECTS OF TEACHERS

8. The Management Panel also propose significant improvements to the career structure from September 1986.

9. The Management Panel has designed the following set of proposals drawing on the common understanding of the professional role of teachers in schools. It has taken into account the criticisms and shortcomings of the existing arrangements and built on its strengths. This has had to be done bearing in mind the financial limits set by the Secretary of State.

10. Within these limits the Management Panel has been able to put forward significantly improved promotion opportunities for teachers. These promotions will be used to meet a variety of criteria and will include: rewarding those undertaking additional responsibilities; recognising that the schools curriculum requirements call for a greater input of skills and experience which are in short supply; acknowledging that the schools location places special demands on the teachers or where the exceptional performance of the teacher's duties call for additional recognition.

11. The acceptance of a systematic system of appraisal should enhance teaching quality and the professional development of all teachers. In addition the outcomes of appraisal should be directly relevant when judgments are made about promotion. These proposals are put forward in the expectation that all parties will co-operate in the development of a scheme of appraisal. An early start would be needed to make a worthwhile contribution to a national framework for appraisal within which LEAs would develop their own schemes.

12. All the salary figures that follow reflect the employers' offer for improvements in current salaries set out in paragraph 6. The comparative figures are shown in Appendix I.

Entry Grade £7,035 to £7,278 (points 5 and 6 of scale 1)

13. All newly appointed teachers will serve two years on this grade. During this time, their performance will be appraised. Provided that they satisfy the criteria for transfer, they will move to the Teacher Grade. During the first year on the grade the teaching load will be reduced to 90 per cent of the normal load in the school.

14. All such teachers will receive counselling, support and induction to afford every opportunity to attain the standard necessary to progress their career.

15. Further development of the Entry Grade arrangements will be needed in discussion with the Teachers.

16. The starting salary matches that currently paid to graduates but additional salary arrangements might be needed for mature entrants.

Teacher Grade £8,037 to £10,509 (point 9 of scale 1 to point 7 of scale 3)

17. All teachers currently being paid below the grade minimum will be lifted to that point by the time the first EG teachers arrive there, other teachers will transfer on their existing point. This will benefit teachers on the lower points and give increases up to 14 per cent in some cases in the first year.

18. Teachers will be expected to undertake the following duties based on a contractual provision common to all teachers on this grade:

Pupils

(1) teach assigned classes;

(2) take an appropriate share of collective staff responsibility to cover the classes of absent colleagues;

(3) plan, prepare, evaluate and review personal teaching methods and programmes in accordance with education authority and school policies;

(4) take an appropriate share of collective responsibility to supervise pupils on arrival at and departure from school and during the school day, including before and after the midday break;

(5) mark, record and report on pupils' work (including homework) and progress in accordance with education authority and school policies;

(6) provide guidance and counsel on educational, social and career matters in accordance with education authority and school pastoral and counselling policies;

Parents

(7) consult and liaise with parents, attending meetings arranged for the purpose;

Curriculum and Examinations

(8) take part in arrangements for presenting pupils in public examinations;

(9) contribute to the preparation and development of courses of study and teaching materials in response to change in public examinations and assessment procedures and in accordance with education authority and school curricular policies;

Staff Matters

(10) take part in performance appraisal in accordance with education authority arrangements;

(11) take part in courses of in-service training and other schemes of professional development;

(12) take an appropriate share of collective staff responsibility for the professional development of colleagues, including new entrants to teaching;

(13) attend staff meetings;

General

(14) carry out such other related duties and responsibilites at the school as may be reasonably allocated, as need arises, by the head.

Senior Teacher Grade £9,456 to £12,087 (point 4 of scale 3 to point 6 of scale 4)

19. In addition to those of the Teacher Grade, duties of the Senior Teaching Grade would include:

(*a*) Acting as a curricular consultant throughout the school.

(*b*) Taking a leading professional role in the review, development and management of assigned curricular, pastoral or organisational activities.

(*c*) Acting as a mentor to newly appointed teachers.

(*d*) Taking responsibility for the school in the brief absence of the head where there are no posts above senior teacher.

20. This promotion post would be available in schools in the ratio of one senior teacher grade for every two posts on teacher grade (including entry grade) with a detailed formula to be worked out.

21. In all but the smallest primary schools, 67 per cent of teachers would be on the teacher grade and 33 per cent on the senior teacher grade. Achieving this proportion would give promotions to 30,000 teachers currently on scales 1 and 2.

22. In the majority of secondary schools, 25 per cent of teachers would be on this grade and lead to promotions for 23,000 teachers in those schools who are currently on scales 1 and 2.

23. This grade would accommodate those teachers on scale 3 who were not promoted to Principal Teacher Grade. Those on the lower points would benefit from being assimilated to the new minimum.

Principal Teacher Grade £11,298 to £14,658 (point 4 of scale 4 to max. of senior teacher plus one increment)

24. In addition to the duties set out for other grades, Principal Teachers' duties would include being accountable for:

supervising, directing, monitoring and appraising the performance of a group of teachers including observing lessons and scrutiny of schemes of work.

25. Such posts would only be established in schools in Group 8 and above. They would be introduced on a sliding scale so that in the average size of secondary school one post in every four will be on this grade. The Management Panel would wish to retain discretion for authorities to exceed the national provision in this respect.

26. The proposals provide for the promotion of some 21,000 teachers as well as for the movement of teachers on the lower points of scale 4 to the new minimum point.

ADDITIONAL ALLOWANCES

27. Even with the changes introduced there will be other specific management duties to be undertaken. These duties will vary in their nature and duration, some may be continuing, others may be completed in a term or year, depending on the circumstances of each school. It is felt to be necessary to set a minimum figure on each allowance and to set a limit to the total expenditure available in each school.

28. It is suggested that the minimum allowances should be set at £500 and be available only in schools in group 8 and above in the following annual amounts:

Group 8	£1,000
Groups 9 & 10	£1,500
Groups 11 & 12	£2,000
Groups 13 & 14	£2,500

29. LEAs would have discretion to appoint Senior Teachers, Principal Teachers and to pay the allowances in paragraph 28 beyond the limits referred to.

30. These allowances would be paid to Senior or Principal Teachers as determined by the authority.

Review of Age Weighting System

31. The Management Panel has been critical of the effect of the existing age weighting system and intends to review this in the near future. There is concern at the effect of the current system on both Primary and Secondary schools. The proposals below are based on the existing system.

DEPUTY HEADS

32. The post and title is retained and differentials improved to produce the following salary levels. These have been phased over two years in the case of Groups 5 to 10 and are based on existing age weightings.

Group	*Proposed Salary Maxima from*		*Management Panel's increased offer from*
	1.9.86	*1.9.87*	*1.9.86 over scale maxima at 1.11.85*
	£	£	%
1 & 2	12,087		16.9
3	12,189		17.9
4	12,300		10.7
5	12,633	12,900	6.2
6	13,167	13,400	7.9
7	14,199	14,400	10.5
8	14,922	15,100	11.0
9	15,433	15,600	9.0
10	16,266	16,400	8.5
11	17,247		10.0
12	18,150		10.0
13	18,669		10.0
14	19,461		10.0

HEADS

33. For head teachers the Management Panel propose to adjust existing pay differentials to recognise the new tasks that will be expected of head teachers.

Group	*Proposed Salary Maxima from 1.9.86* £	*Management Panel's increased offer from 1.9.86 over scale maxima at 1.11.85* %
1	12,714	12.6
2	13,026	11.0
3	13,572	11.0
4	14,571	11.0
5	15,669	11.0
6	16,689	11.0
7	17,625	11.0
8	18,780	11.0
9	20,133	11.0
10	21,345	11.0
11	22,953	11.0
12	24,363	11.0
13	25,599	11.0
14	26,994	11.0

SPECIAL SCHOOLS

34. These proposals cover the majority of teachers in maintained schools but do not cover the arrangements for special schools. The Management Panel expects the same principles to be applied to special schools.

12 *September* 1985

Appendix 1

SALARY SCALES REFLECTING EMPLOYERS' OFFER

Scale Point	Existing Salary	*Increase of £480/5% + 1%*	NEW STRUCTURE From 1/9/86 (This does not take into account the salary increase payable from 1/4/86.)	£ increase	% inc.
0	5,442	*5,976*		534	9.81
1	5,694	*6,231*		537	9.43
2	5,883	*6,423*		540	9.18
3	6,072	*6,612*		540	8.89
4	6,252	*6,795*		543	8.69
5	6,489	*7,035*	ENTRY	546	8.41
6	6,732	*7,278*	GRADE	546	8.11
7	6,975	*7,524*		549	7.87
8	7,230	*7,782*		552	7.63
9	7,482	*8,037*	TEACHER GRADE	555	7.42
10	7,734	*8,292*		558	7.21
11	8,004	*8,565*		561	7.01
12	8,280	*8,844*		564	6.81
13	8,556	*9,123*		567	6.63
14	8,886	*9,456*		570	6.41
15	9,207	*9,774*		573	6.23
16	9,597	*10,173*	SENIOR TEACHER GRADE	576	6.00
17	9,915	*10,509*		594	5.99
18	10,287	*10,905*		618	6.01
19	10,659	*11,298*		639	5.99
20	11,031	*11,694*		663	6.01
21	11,403	*12,087*		684	6.00
22	11,931	*12,648*	PRINCIPAL TEACHER GRADE	717	6.01
23	12,363	*13,104*		741	5.99
24	12,963	*13,740*		777	5.99
25	13,395	*14,199*		804	6.00
26	N/A	*14,658*		N/A	N/A

Appendix 2

Deputy Head Teachers' Scale Maximum at Offer Level

Group	Current maximum	*Maximum with 6% Increase*
	£	£
Below 4	9,753	10,338
4	10,482	11,112
5	11,223	11,895
6	11,514	12,204
7	12,123	12,849
8	12,681	13,443
9	13,356	14,157
10	14,142	14,991
11	14,790	15,678
12	15,567	16,500
13	16,011	16,971
14	16,689	17,691

Head Teachers' Scale Maximum at Offer Level

Group	Current maximum	*Maximum with 6% Increase*
	£	£
1	10,653	11,292
2	11,073	11,736
3	11,535	12,228
4	12,384	13,128
5	13,317	14,115
6	14,184	15,036
7	14,979	15,879
8	15,963	16,920
9	17,112	18,138
10	18,141	19,230
11	19,509	20,679
12	20,706	21,948
13	21,756	23,061
14	22,941	24,318

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HOUSE OF COMMONS

First Report from the

TREASURY AND CIVIL SERVICE COMMITTEE

Session 1985–86

THE FORM OF SUPPLY ESTIMATES, 1986–87

Together with the Proceedings of the Committee and Appendices

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Ordered by The House of Commons *to be printed*
26 *November* 1985

LONDON
HER MAJESTY'S STATIONERY OFFICE
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The Treasury and Civil Service Committee is appointed under S.O. No 99 to examine the expenditure, administration and policy of the Treasury, Management and Personnel Office, the Board of Inland Revenue, and the Board of Customs and Excise and associated public bodies, and similar matters within the responsibilities of the Secretary of State for Northern Ireland.

The Committee consists of a maximum of eleven members, of whom the quorum is three. Unless the House otherwise orders, all Members nominated to the Committee continue to be members of the Committee for the remainder of the Parliament.

The Committee has power:

(a) to send for persons, papers and records, to sit notwithstanding any adjournment of the House, to adjourn from place to place, and to report from time to time;

(b) to appoint specialist advisers either to supply information which is not readily available or to elucidate matters of complexity within the Committee's order of reference.

The Committee has power to appoint one sub-committee and to report from time to time the minutes of evidence taken before it. The sub-committee has power to send for persons, papers and records, to sit notwithstanding any adjournment of the House, and to adjourn from place to place. It has a quorum of three.

Friday 9 *December* 1983

The following were nominated as members of the Treasury and Civil Service Committee:

Mr Anthony Beaumont-Dark
Mr John Browne
Mr Nicholas Budgen
Mr Mark Fisher
Mr Terence L Higgins
Mr Ralph Howell
Mr Peter Lilley
Mr Austin Mitchell
Mr Brian Sedgemore
Mr John Townend
Mr Richard Wainwright

Mr Terence L Higgins was elected Chairman on 13 December 1983.

The following change in the membership of the Committee has been made. Friday 27 January 1984: Mr Peter Lilley discharged; Mr Roger Freeman appointed.

The cost of printing this Report is estimated by Her Majesty's Stationery Office at £3,240.

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FIRST REPORT

The Treasury and Civil Service Committee has agreed to the following Report:

THE FORM OF SUPPLY ESTIMATES, 1986–87

1. A number of reports from this Committee,[1] from our predecessor Committee[2] and from the Procedure (Finance) Committee[3] have laid stress on the importance of clarity in government expenditure publications laid before the House.

2. The latest Treasury plans for further improvements in the form of Supply Estimates for 1986–87 are attached to this report (Appendix 1). These show how the form of the Estimates might reflect more accurately the management structures and objectives used by departments to plan and control their expenditure. Secondly, it is suggested that links between the Estimates and the Public Expenditure White Paper should be improved, to enhance the value of the Estimates. Finally, the government intend to set targets in the Estimates for the running costs of each department, a kind of second-tier cash limit, bringing together Estimates of pay and other general administrative costs. Examples of what these changes might mean for the format and structure of the Estimates are included in Appendix 2.

3. We are grateful to the Treasury for their full explanation of these latest proposals, and are content that the 1986–87 Estimates should be laid before the House in the form suggested, provided that Departments are prepared to respond to inquiries from select committees about cost breakdowns which no longer appear on the face of the Estimates. When we ourselves have had an opportunity to study the 1986–87 Estimates in their new presentation, together with the next Public Expenditure White Paper (which of course will have a greater departmental emphasis than previously) we intend to make a further report, setting out our final comments on the attached proposals.

26th November 1985

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[1] Second Report from the Treasury and Civil Service Committee, HC(1984 85)110; Seventh Report, HC(1984–85)323; Ninth Report, HC(1984–85)382; Tenth Report, HC(1984–85)544; and Eleventh Report, HC(1984–85)545.
[2] Sixth Report from the Treasury and Civil Service Committee, HC(1981–82)137.
[3] HC(1982–83)24–I.

PROCEEDINGS OF THE COMMITTEE RELATING TO CONSIDERATION OF THE REPORT

TUESDAY 26 NOVEMBER 1985

Members present:

Mr Terence L Higgins, in the Chair

Mr Anthony Beaumont-Dark
Mr John Browne
Mr Nicholas Budgen
Mr Mark Fisher
Mr Roger Freeman
Mr Ralph Howell
Mr Austin Mitchell
Mr Brian Sedgemore
Mr John Townend
Mr Richard Wainwright

Draft Report (The Form of Supply Estimates, 1986–87) proposed by the Chairman, brought up and read.

Ordered, That the Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 3 read and agreed to.

Several papers were ordered to be appended to the Report.

Resolved, That the Report be the First Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

APPENDIX 1

Memorandum by HM Treasury

THE FORM OF SUPPLY ESTIMATES 1986–87

Introduction

This memorandum describes the Treasury's plans for further improvements in the form of Supply Estimates for 1986–87. The Government hopes that these changes, which are in line with the wider programme of developments in expenditure publications, will enhance the value of the Estimates to Select Committees and to the House generally in view of its responsibilities for Supply.

Financial management

2. The Committee will be aware of previous progress in adjusting the form of Estimates to reflect developments in financial management. (Memoranda on the financial management initiative and Estimates in 1984–85 and 1985–86 were sent in December 1983 and July 1984.) The aim is to reflect more accurately in the Estimates the management structures and objectives used by departments to plan and control their expenditure. As financial management systems (especially decentralised budgetary control systems) develop, steady progress is being made in adapting formats to show more clearly the expenditure of each major function or responsibility centre within a vote.

3. These changes mainly affect the presentation of administrative expenditure, including running costs, although some programme votes are also involved. In 1985–86 main Estimates for example, the structure of the Department of Employment administration Estimate (class IV, vote 16) was adjusted to emphasise how running costs were divided between its various organisations; previously the presentation had focussed on a breakdown into pay and several categories of general administrative expenditure. The restructuring mirrored that of a number of other departments in previous years, as described in the previous memoranda.

4. Other changes in 1985-86 reflected new ways of managing expenditure programmes. The number of Health votes (class XI) increased from two to three and they were reorganised to show clearly which expenditure fell within the responsibility of the NHS management board, formed as a result of the Griffiths enquiry. Some Environment votes (class VIII) were changed to bring together all the expenditure, including finance for local authorities, on the Urban programme.

5. Further developments are expected in 1986–87, often following the same approach as the Employment vote. The main administration votes of the Inland Revenue, Ministry of Agriculture, Fisheries and Food, and Department of Education and Science are all likely to be presented on an organisational basis; and the Home Office, which made major changes in 1984–85, now expects also to restructure its prison department Estimate. The Department of Trade and Industry plans to reduce the number of its votes (excluding votes for privatisation expenses) from seven to four, partly to enable the new larger votes to reflect its developing resource allocation and management systems; and the Property Services Agency plans to reflect the way its administration costs are divided between defence and civil work by including them in the relevant accommodation services vote instead of in a separate administration vote. Most administration votes should have adopted a primary split of running costs by function or organisation in 1986–87, excluding the votes of small homogeneous departments where such a split would have little meaning. In some cases, however, budgetary control systems are not yet sufficiently developed and tested for vote formats to be adjusted next year.

Links with the public expenditure White Paper

6. Supply Estimates are already organised to show how the provision for which Parliamentary approval is sought relates to the Government's expenditure plans—published in the preceding public expenditure White Paper (PEWP). The Treasury has recently clarified the inevitably complex relationship between Supply and public expenditure in a section in the new Summary and Guide to main Estimates (Cmnd 9450). And Treasury proposals, which the Committee has accepted, on the treatment of receipts will facilitate the read-across between the PEWP and Estimates. As the Committee will be aware, the next PEWP

is to be presented primarily on a departmental basis (see Appendix B to the TCSC 10th Report, HC (1984–85) 544). This change offers an opportunity for further improvements in the links between the PEWP and Estimates.

7. An important aim of better links is to enable Select Committees and others to view a department's Estimates in the context of its chapter in the PEWP, which describes the aims and outputs of expenditure and sets out the medium term plans. The TCSC 2nd Report[1] (paragraph 19) drew attention to the distinction between Estimates as an instrument for operating Parliamentary Supply procedures and as an information document. The Treasury believes their value in the former role will be enhanced if they are seen as one among a consistent group of documents, which also includes the information about expenditure plans in the PEWP.

8. As the next step towards this aim, 1986–87 main Estimates will be re-grouped into twenty new classes that each correspond to a single chapter in the 1986 PEWP. At the same time improvements will be made in the way in which information on the functional classification of expenditure in Estimates is presented, for consistency with its presentation in departmental tables in the PEWP. Each class of Estimates will start with a table showing the functional headings used in the PEWP, the allocation of direct public expenditure under each heading to votes and the amount of expenditure which appears in each vote but is not classified as direct public expenditure and does not therefore appear in that form in the PEWP. To help readers follow a particular category of expenditure all the way from the PEWP into the appropriate detailed subheads and items in Estimates, a similar presentation will be used in the Summary part of each Estimate. The technical table in Part IV of Estimates will then no longer contain additional information and will be discontinued.

9. In due course, the Treasury hopes it will prove practicable to show more clearly how Supply expenditure in individual Estimates which is not classified as direct public expenditure is nevertheless consistent with the PEWP plans. This is not possible for 1986–87, but the relationship will continue to be explained in aggregate in the Summary and Guide.

Running costs

10. The Committee will be aware of improvements the Government is making in the way in which it plans and controls its running costs. Further changes in some Estimates, in line with those already made or planned to reflect developments in financial management, are proposed, so that the format of Estimates continues to reflect the way departments manage, monitor and control their running costs in practice.

11. The Chief Secretary to the Treasury announced on 24 May that the Government intended to improve the arrangements for controlling its running costs, under which targets will be set in the public expenditure Survey to cover the running costs, including manpower, of each department (Hansard Col 562). Rather than making provision for pay in line with a central assumption about pay increases, together with a separate estimate of the cost of general administrative expenditure, limits on total running costs expenditure will be set for the following year, and announced to Parliament. As with cash limits, departments will monitor and control their running costs against these agreed limits and if, exceptionally, a limit has to be changed during the year Parliament will be informed. Similarly, should there be any breaches of the limits, these will be published in the annual cash limits outturn White Paper, which is normally published in July. While enhancing central control and the downward pressure on aggregate running costs this approach will also permit greater flexibility to departments in managing their running costs budgets, consistently with developments in financial management.

12. The Treasury proposes therefore to present relevant Estimates to Parliament in a format that focusses on the total cash provision sought for running costs in each vote. The objective will be to include all categories of running costs on a vote in the same line or lines (ie subheads or items). If votes have been structured to reflect the responsibilities of separate budget holders (see eg the Department of Employment example mentioned in paragraph 3) the total running costs of each would appear as a separate line; but a breakdown into the separate components of running costs (pay, personnel overheads, office services etc) would not generally be shown in Estimates. Budget holders need flexibility to allocate and re-allocate their resources within their total budget if they are to operate

[1] "The Structure and Form of Financial Documents presented to Parliament", HC (1984–85) 110.

efficiently, and the detailed breakdowns hitherto provided in some Estimates have, in any case, often been substantially affected by switching expenditure in the course of the year and they have therefore often proved a poor guide to the actual pattern of expenditure. However, accurate breakdowns of outturn will of course be available and some Select Committees may decide to seek this sort of outturn information from their departments.

13. Some details of these changes may need to be deferred beyond 1986–87. For example, some elements of running costs may be held by budget holders apart from the main functional or line management responsibility centres, or practical problems may inhibit complete adjustment of vote structures. Nevertheless, the Government aims to make as many changes as possible in 1986–87 Estimates.

Conclusion

14. This memorandum describes some changes to the form of Estimates designed to bring them closer to the way expenditure is planned and controlled by the Government. Subject to any comments the Committee may have, it proposes to implement these changes as fully as possible in 1986–87.

H M TREASURY
22 *October* 1985

APPENDIX 2

Illustrative Examples provided by HM Treasury

FORM OF SUPPLY ESTIMATES, 1986–87

Letter to the Clerk to the Committee

My letter of 22 October to you enclosed a note on the form of Supply Estimates in 1986–87. It has been suggested that your Committee would welcome some illustrative examples of the changes described in the note; these are now ready and I enclose copies.

The first and third topics of the note—developments in financial management and running costs—are closely linked and an example of how the Ministry of Agriculture, Fisheries and Food intend to restructure their administration vote in 1986–87 is attached to illustrate both. Hitherto the structure has focussed on a disaggregation into pay and several other categories of administrative expenditure. In future, it will show the running costs of 18 responsibility centres, accommodation costs (which are part of running costs) and capital expenditure.

The second topic described in the note is improvements in the read-across from the public expenditure White Paper (PEWP) to the Estimates. An outline of how this might affect the vote for schools, further education etc is attached, together with an extract of how Department of Education and Science expenditure might be shown in the 1986 PEWP. For ease of reference, I also attach the same vote and table in 1985–86. The 1986 PEWP table brings together that public expenditure by central government which is also voted expenditure (ie borne on Supply Estimates). Within this general category, expenditure continues to be classified in the table to several functional headings, eg "Schools: primary, secondary and other". The same headings are used in the Summary to the vote. To enable users of the Estimate to compare its contents with the appropriate PEWP figures, expenditure in the Estimate which does not fall within a functional heading is separately identified: ie receipts from the European Communities are shown in an "of which" line, and transfers within the public sector which do not score as direct public expenditure at the end of the Summary.

In general, the net provision for 1986–87 shown against a functional heading in the vote Summary will therefore be directly comparable with the figure shown for the same year against the same heading in the PEWP. In some cases, however, a functional heading covers expenditure on more than one vote and the read-across can only be completed by a table showing the allocation to votes of expenditure under each functional heading, as described in paragraph 8 of the note.

In previous years neither the headings nor the figures in the Summary were so closely aligned with those in the PEWP. Only the broad headings, eg "schools", were the same in both documents. Expenditure was classified only imprecisely in the Estimate Summary; a precise classification was given in the table in Part IV at the end of the vote but it was not straightforward to relate the information in that table to the detailed subheads and items of the vote.

I should add that the examples are not, of course, finalised and are subject to further refinement before main Estimates for 1986–87 are presented to the House, as well as to any comments the Committee may have on the note.

A copy of the examples is also being sent to the PAC.

HM Treasury
29 *October* 1985

LIST OF EXAMPLES

A Ministry of Agriculture, Fisheries and Food administration vote. Planned presentation in 1986–87.

B MAFF administration vote, 1985–86.

C Department of Education and Science, vote for schools, further education etc. Outline of presentation in 1986–87. Details below subhead level are not included in this outline, for simplicity; they would be incorporated in a full version before it was presented to Parliament.

D Extract from 1986 DES public expenditure White Paper table.

E DES vote for schools, further education etc, 1985–86

F Extract from 1985 DES White Paper chapter.

A
1986–87, CLASS IV, 5

£000,000,000

Amount required in the year ending 31 March 1987 for expenditure by the Ministry of Agriculture, Fisheries and Food on departmental research, advisory services and administration and certain other services.

The Ministry of Agriculture, Fisheries and Food will account for this vote.

Net total
Allocated in Vote on Account (HC 00)
Balance to complete

II **SUMMARY AND SUBHEAD DETAIL**

SUMMARY

1984–85	*1985–86*		*1986–87*		
Outturn £'000	*TOTAL provision £'000*		*Gross provision £'000*	*Appropriations in aid £'000*	*Net provision £'000*
		Departmental research, advisory services and administration.			
		Gross total			
		Deduct:			
		Total appropriations in aid			
		Net total			
	Forecast Outturn £'000				

1984–85	*1985–86*	**SUBHEAD DETAIL**	*1986–87*
Outturn	*Total Provision*		*Provision*
£'000	*£'000*		*£'000*
		DEPARTMENTAL RESEARCH, ADVISORY SERVICES AND ADMINISTRATION	
00,000	**00,000**	**A1 Headquarters Organisation: Running costs** The Ministry's HQ organisation is primarily concerned with policy development and advice and is situated in central London with outstations at Cambridge, Chessington, Guildford and Tolworth. Four Ministers and c. staff at 1 April 1986 decreasing to d by 31 March 1987 (provision sought in 1985–86 was for e decreasing by f).	**00,000**
	000	(1) Senior Management Four Ministers and the Permanent Secretary with their supporting secretariats and the Ministry's parliamentary and appointments sections. (a) Ministers salaries £000 (b) Permanent Secretary and Secretariats: running costs £'000.	000
	0,000	(2) Agricultural Commodities General agricultural policy in the UK and under the CAP, the development of policy for individual commodities and the co-ordination of EC matters and external relations.	0,000
	0,000	(3) Land and Resources Advice and policy on agricultural resources including labour, training, finance and taxation; land improvement, use and tenure; conservation of the environment; less favoured areas and assistance for capital and other improvements; arterial drainage, coast and flood protection; animal health and welfare, meat hygiene; horticulture; plant health, plant variety rights and seeds; and the provision of economic and statistical services for the Ministry.	0,000
	0,000	(4) Food and Marketing Advice and policy on food and marketing including alcohol, potatoes and tropical foodstuffs; food standards and civil emergencies affecting the agriculture, fisheries and food industries.	0,000
	000	(5) Chief Scientists Group Advice on scientific policy and the allocation of research and development resources in agriculture, fisheries and food including the commissioning of R&D work with "contracting" organisations both within and outside the Ministry.	000
	00,000	(6) Common Services Advice on and provision of finance, legal management, manpower, personnel and office services including the provision of the Ministry's information and computer services.	00,000

(Headquarters running costs in ADAS, Fisheries Department and Food Science are provided for in subheads A2 and A3).

00,000	**00,000**	**A2 Agricultural development and advisory service: running costs**	**00,000**
		Provision of a wide range of advisory and other services, including diagnostic and analytical services, for the benefit of the agricultural industry, supported by investigations into new methods of production evaluation and development of the results of research, and undertaking crop and animal production experiments. ADAS also provides professional, scientific and technical advice to Ministers, assists in the administration of Ministry schemes and undertakes certain statutory duties. In support of these activities it runs χ experimental farms and horticultural stations, χ agricultural science laboratories with χ sub-centres, χ veterinary laboratories and χ veterinary investigation centres.	
		c staff at 1 April 1986 decreasing to d by 31 March 1987 (provision sought in 1985–86 was for e decreasing by f).	
	00,000	(1) Agriculture Service	00,000
	0,000	(2) Agricultural Science Service	0,000
	0,000	(3) Land and Water Service	0,000
	00,000	(4) State Veterinary Service	00,000
	0,000	(5) Other	0,000
00,000	**00,000**	**A3 Fisheries and food science: running costs**	**00,000**
		Fisheries policy including the CFP, conservation and utilisation of fish stocks, assistance for the fishing industry, monitoring and assessment of fish stocks, fisheries research and development, research into the aquatic environment, and food science and research. In support of these activities the Department runs χ fisheries laboratories, χ research vessels and χ food science laboratories.	
		c staff at 1 April 1986 decreasing to d by 31 March 1987 (provision sought in 1985–86 was for e decreasing by f).	
	00,000	(1) Fisheries Department	00,000
	0,000	(2) Food Science	0,000
00,000	**00,000**	**A4 regional administration: running costs**	**00,000**
		Responsible for representing the Minister and administering the Ministry's policies and schemes at local level through a network of χ regional and χ divisional offices and providing administrative support for ADAS.	
		c staff at 1 April 1986 decreasing to d by 31 March 1987 (provision sought in 1985–86 was for e decreasing by f).	
	0,000	(1) Eastern Region	0,000
	0,000	(2) Northern Region	0,000
	0,000	(3) South Eastern Region	0,000
	0,000	(4) South Western Region	0,000
	0,000	(5) Midlands and Western Region	0,000
00,000	**00,000**	**A5 accommodation services: running costs**	**00,000**
	00,000	(1) Accommodation Charges	00,000
	0,000	(2) Fuel and Utilities	0,000

00,000	**00,000**	**A6 capital expenditure** In support of administrative and other services including expenditure at Ministry laboratories, experimental centres, investigation centres and on research vessels.	**00,000**
	0,000	(1) Headquarters organisation, including £0,000 on computers and information technology.	0,000
	0,000	(2) ADAS	0,000
	0,000	(3) Fisheries and Food Science, including £0,000 on the construction of a replacement research vessel.	0,000
	00	(4) Other	00
000,000	000,000	GROSS TOTAL	000,000
£'000	*£'000*	*Deduct:*	*£'000*
0,000	**0,000**	**AZ APPROPRIATIONS IN AID**	**0,000**
	0,000	(1) Receipts in respect of ADAS activities	0,000
	0,000	(2) Receipts in respect of other activities	0,000
000,000	**000,000**	NET TOTAL	**000,000**

B
1985–86, Class III, 5

CLASS III, VOTE 5

DEPARTMENTAL RESEARCH, ADVISORY SERVICES AND ADMINISTRATION (MINISTRY OF AGRICULTURE, FISHERIES AND FOOD)

This vote is treated as a cash limit.

2. The vote covers the staff and administrative costs of the Ministry together with capital and other current expenditure on in-house research and advisory services. Expenditure on external services, subject to a cash limit, is contained in vote 4.

3. Some 45 per cent of the staff employed by the Ministry are in the professional, scientific and technical grades and are mainly concerned with the provision of advice, with research and development and with other services for the benefit of the agriculture, fisheries and food industries. A further 49 per cent are in the administrative grades and the balance in the industrial grades. In addition to its headquarters, 5 regional and 19 divisional offices, the Ministry runs 19 experimental farms and horticultural stations, 10 agricultural science laboratories with 6 sub-centres, 2 veterinary laboratories and 23 veterinary investigation centres, 2 food science laboratories, 5 fisheries laboratories and a number of other establishments including 2 research vessels.

4. In total the vote assumes 11,441 staff at 1 April 1985 decreasing to 11,391 by the end of 1985–86 compared with 11,466 staff at 1 April 1984 and 12,049½ at 1 April 1983. The table headed "the apportionment of administrative expenditure" at the end of the vote gives a broad allocation of the costs incurred and the total staff numbers involved in support of the Ministry's programmes.

5. The net provision for 1985–86 is £207 million, compared with a supply provision of £200 million and forecast outturn of £196 million in 1984–85. Outturn in 1983–84 was £191 million.

I **£207,248,000**

Amount required in the year ending 31 March 1986 for expenditure by the Ministry of Agriculture, Fisheries and Food on departmental research, advisory services and administration and certain other services.

The Ministry of Agriculture, Fisheries and Food will account for this vote.

	£
Net total	207,248,000
Allocated in Vote on Account (HC8)	89,785,000
Balance to complete	117,463,000

II

1983–84 Outturn £'000	*1984–85* Total provision £'000	SUBHEAD DETAIL	*1985–86* Provision £'000
		PROGRAMME 3.7	
		DEPARTMENTAL RESEARCH, ADVISORY SERVICES AND ADMINISTRATION	
109,478	**114,468**	**A1 Salaries etc**	**118,255**
98		(1) Salaries etc of 4 Ministers.	101
48,430		(2) Salaries etc of 5,978 staff in the Ministry of Agriculture, Fisheries and Food at 1 April 1985 decreasing to 5,952 by 31 March 1986 (provision sought in 1984–85 was for 5,982 decreasing by 4 in 1984–85) excluding staff in the Agricultural Development and Advisory Service, the Fisheries Department and the Plant Variety Rights Office.	50,311
57,179		(3) Salaries etc of 4,718 professional, scientific and technical staff in the Agricultural Development and Advisory Service at 1 April 1985 decreasing to 4,701 by 31 March 1986 (provision sought in 1984–85 was for 4,736 decreasing by 18 in 1984–85).	59,096
8,085		(4) Salaries etc of 737 staff in the Fisheries Department at 1 April 1985 decreasing to 730 by 31 March 1986 (provision sought in 1984–85 was for 740 decreasing by 3 in 1984–85) including sea fisheries inspectorate and fisheries laboratories.	7,781
68		(5) Proportions of salaries etc equivalent to 8 full time staff in the Plant Variety Rights Office at 1 April 1985 and remaining at this level until 31 March 1986 (No change from 1984–85). For non-administrative expenditure see Vote 4 subhead B4(2).	68
120		(6) Salaries etc of all seconded staff estimated to average 11 in 1985–86.	124
488		(7) Other expenses including advances of salary (322,000) for an estimated 138 staff on compulsory transfer.	774
37,599	**42,358**	**A2 Accommodation etc: current expenditure**	**42,061**
32,220		(1) Accommodation charge (comprising rents, rates, maintenance, minor new works and associated administrative costs) payable to PSA.	33,173
4,306		(2) Fuel and utilities, payable to PSA (on basis of actual usage).	4,135
2,149		(3) Other payments to PSA including custody guards (£247,000), conference facilities (£168,000), and minor works in specialised buildings (£1,568,000).	2,290
3,683		(4) Upkeep etc of Ministry offices including cleaning and payments to private contractors for small jobs.	2,463
4,273	**4,588**	**A3 Telecommunications: current expenditure**	**4,802**
284		(1) British Telecom telephone operators (21).	295
4,304		(2) Telephone call charges (£2,126,000), rentals etc.	4,507
1,727	**1,847**	**A4 Computers and office technology: current expenditure**	**2,245**
		Mainly hire and maintenance of equipment and payment for programming undertaken by outside contractors.	

20,198	20,827	**A5 Other general administrative current expenditure**	22,630
	10,055	(1) Travelling, subsistence and removal expenses etc. for ADAS staff.	10,509
	3,608	(2) Travelling, subsistence and removal expenses etc. for all other staff.	3,839
	304	(3) Maintenance of official vehicles.	333
	1,634	(4) Postal charges.	1,610
	2,582	(5) Stationery, printing, mainly from HMSO.	3,134
	844	(6) Libraries, publications, translations etc including services provided by Ordnance Survey.	963
	1,800	(7) Other expenditure including staff training, welfare and protective clothing.	2,242
4,123	5,293	**A6 Administration: capital expenditure**	6,215
	510	(1) Telecommunications equipment	400
	3,660	(2) Computers and office technology including the purchase of minicomputers for the Ministry and the Intervention Board for Agricultural Produce.	4,686
	898	(3) Furniture and fittings.	912
	225	(4) Official vehicles.	217
250	606	**A7 Departmental publicity**	632
	345	(1) Payment for services provided by the Central Office of Information.	358
	261	(2) Other expenditure mainly provision of exhibition stands and exhibits at 14 major agricultural events and demonstrations, support for 8 "county" shows and other specialist ADAS demonstrations.	274
5,019	4,384	**A8 Agricultural Development and Advisory Service: capital expenditure**	3,638
		Mainly expenditure on plant and machinery, certain specialised buildings, laboratory, scientific and field equipment for	
	2,456	(1) Experimental centres	1,892
		12 experimental husbandry farms (5,149 hectares) and 7 experimental horticulture stations (478 hectares) investigating new methods of agricultural and horticultural production; evaluating and developing the results of research, and undertaking crop and animal production experiments.	
	923	(2) Agricultural science laboratories	999
		4 central laboratories (Slough, Tolworth, Worplesdon including Norwich, and Harpenden), 6 regional laboratories and 6 sub-centres responsible for analytical and diagnostic work in support of research and development, chargeable services to farmers, statutory and advisory work etc. The areas covered are plant diseases, agricultural pests, animal nutrition, soil science, pollution, and pesticide residues and related wildlife problems.	
	568	(3) Veterinary laboratories	414
		(*a*) Central veterinary laboratories (Weybridge and Lasswade) and 23 veterinary investigation centres in England and Wales responsible for diagnostic and analytical chargeable services; laboratory work in support of statutory, development and advisory functions; and research and investigation into animal and poultry diseases including field trials. £361,000	
		(*b*) Cattle Breeding Centre (Reading) and 1 sub-station responsible for artificial insemination services and research into artificial insemination and fertility in cattle and pigs. £53,000	

	437	(4) Other central and regional activities Advisory, statutory, and development work (including field trials, promotions and demonstrations) undertaken by the remainder of the Ministry's advisory staff stationed throughout England and Wales.	333
9,057	9,452	**A9 Agricultural Development and Advisory Service: current expenditure** Mainly expenditure on livestock, farm and horticultural supplies, maintenance and repairs of equipment, fuel, chemicals and fertilisers, glassware and other consumables, display materials etc, and payments for statistical, meteorological, aerial survey and other contract services for	9,897
	4,695	(1) Experimental centres.	4,768
	920	(2) Agricultural science laboratories.	1,407
	1,821	(3) Veterinary laboratories. (*a*) Central veterinary laboratories and veterinary investigation centres. £1,819,000 (*b*) Cattle Breeding Centre (Reading) and substation. £120,000	1,939
	2,016	(4) Other central and regional activities.	1,783
555	180	**A10 Food Science Laboratories: capital expenditure** The laboratories, located in London and Norwich, undertake scientific investigation and provide advice on food technology, safety, composition and nutrition.	187
213	220	**A11 Food Science Laboratories: current expenditure** Mainly expenditure on chemicals, glassware and other consumables.	214
793	2,574	**A12 Fisheries: capital expenditure** Mainly expenditure on research and development work carried out at 5 Ministry laboratories, which use 2 Ministry research vessels as well as chartering other vessels on a short-term basis. The main investigations cover the aquatic environment, marine fisheries, shellfish fisheries, salmon and fresh water fisheries, fish cultivation and fish utilisation.	3,869
	1,715	(1) Research vessels. Includes provision (£3,356,000) for payments on the construction of a replacement research vessel (see table 2).	3,396
	859	(2) Ministry laboratories.	473
2,136	2,213	**A13 Fisheries: current expenditure**	2,097
	1,247	(1) Research vessels.	1,091
	929	(2) Ministry laboratories.	961
	37	(3) Miscellaneous.	45
4,440		*Royal Botanic Gardens, Kew*	
199,861	209,010	**Gross total**	216,742
		Deduct:	
8,928	9,406	**AZ Appropriations in aid**	9,494
	1,501	(1) Recoveries in respect of services rendered Including telephone services to other departments (£282,000), work undertaken for the National Coal Board in relation to the restoration of open cast coal sites (£554,000) and loaned and seconded staff (£124,000).	1,631
	785	(2) Fees received for licences, permits, departmental services Including charges in respect of product licences issued under the Medicines Act 1968 (£423,000).	809

4,120	(3) Sales of produce by experimental centres (subheads A8 and A9).		3,839
1,600	(4) Fees, charges and other receipts for services rendered by ADAS (subheads A8 and A9) Including charges for agricultural science (£531,000) and veterinary services (£726,000) under the Agricultural Services Scheme Order 1972.		1,681
1,400	(5) Miscellaneous receipts Including recovery of VAT input tax (£504,000), travel expenses refunded by EC for officials attending EC meetings (£283,500), the Agricultural Chemicals Approval Scheme (£112,000) and contributions from the European Agricultural Guidance and Guarantee Fund for socio-economic advisers (£2,500).		1,534
190,933	**199,604**	Net total	**207,248**
	Forecast outturn £'000 **195,726**		

III EXTRA RECEIPTS PAYABLE TO THE CONSOLIDATED FUND

1983–84	*1984–85*		*1985–86*
£'000	*£'000*	In addition to appropriations in aid there are the following estimated receipts:	*£'000*
29	88	(1) Sums received in respect of licence fees under the Dumping at Sea Act 1974	192
231	1,298	(2) Repayments by the Post Office	26
81	75	(3) Miscellaneous	75
1,134		*Recoveries and fees in excess of those used in subhead AZ*	
1,475	1,461	Total	293

IV ANALYSIS OF THE VOTE BY PROGRAMME AND TYPE OF EXPENDITURE: 1985–86

		Nature of expenditure			*£'000*	
		Public expenditure			*Other*	*Total*
Programme		*Current*	*Capital*	*Total*		
2.7	Net payments to the European Community Institutions	−3	—	−3	—	−3
3.7	Departmental research, advisory services and adminstration	194,028	13,405	207,433	—	207,433
4.13	Nationalised industries external finances	−182	—	−182	—	−182
	Total	193,843	13,405	207,248	—	207,248

TABLE 1

APPORTIONMENT OF ADMINISTRATIVE EXPENDITURE

Function	*Class and Vote*	*Broad allocation to functions*	
		Salaries etc. and administrative expenditure £ million	*Numbers of staff*
Market regulation and production support	111.3	9.0	640
Other agricultural support	111.3	11.7	830
Animal health	111.3	26.2	1,640
Support for the fishing industry	111.4	4.9	370
Land drainage and flood protection	111.3	1.3	80
Other agricultural and food services	111.4	19.8	1,300
Departmental research, advisory services and administration	111.5	110.6	6,470
Civil Defence	111.4	12.7	111
Total Subheads A1–A6		196.2	11,441

TABLE 2

Long term capital projects—details of works services costing over £1 million

Project	*Year of start/original estimate of year of completion*	*Current estimate of year of completion*	*Original estimate at 1985–86 prices*	*Probable expenditure to 31 March 1985 at 1985–86 prices*	*Estimate provision for 1985–86*	*Estimated expenditure after 31 March, 1986 at 1985–86 prices*
			£'000	*£'000*	*£'000*	*£'000*
Construction of fisheries research vessel [subhead A12(1)]	1983–84/ 1986–87	1987–88	5,088	2,660	3,356	2,035

C

1986–87, Class XII, 1

SCHOOLS, FURTHER EDUCATION AND OTHER EDUCATIONAL SERVICES

I **£xxx,xxx,xxx**

Amount required in the year ending 31 March 1987 for.....

The Department of Education and Science will account for this vote.

Net total
Allocated in Vote on Account (HC)
Balance to complete

II **SUMMARY AND SUBHEAD DETAIL**

1984–85 Outturn £'000	*1985–86* Total provision £'000	SUMMARY	*1986–87* Gross provision £'000	Appropriations in £'000	Net provision £'000
		10.1 Schools			
x	x	Primary, secondary and other	x	x	x
x	x	Other (supporting services etc)	x	x	x
		10.2 Higher and further education			
x	x	Voluntary and direct grant	x	x	x
(x	x	of which: net contributions to the European Communities		x	x)
x	x	Adult	x	x	x
		10.4 Miscellaneous education Services, research and administration			
x	x	Youth service	x	x	x
x	x	Research and other services	x	x	x
x	x	**Other (non-public) expenditure**	x	x	x
x	x	Gross total	x	x	x
		Deduct:			
x	x	Total appropriations in aid	x	x	x
x	x	Net Total	x	x	x

Forecast outturn £'000
x

SUBHEAD DETAIL

Section A: **SCHOOLS: Primary, Secondary and other**
A1 Grants to special schools: capital
A2 Aided and special agreement schools: building grants and loans.
AZ Appropriations in aid.

Section B: **SCHOOLS: Other (supporting services etc.)**
B1 Grants to direct grant schools.
B2 Grants to music and ballet schools.

Section C: **HIGHER AND FURTHER EDUCATION: Voluntary and direct grant**
C1 Grants for further education: grant aided colleges.
C2 Grants and loans for further education: capital
C3 Grant aided colleges: restructuring including redundancies.
C4 Royal College of Art: grant in aid.
C5 Royal College of Art: grant for capital expenditure.

C6 Cranfield Institute of Technology: grant in aid.
C7 Cranfield Institute of Technology: grant for capital expenditure.
C9 Teachers Training: grants for the training or retraining of Teachers in craft, design and Technology
CZ Appropriations in aid.
(1) Payments by.....
(2) Reimbursements from the European Agricultural Guidance and Guarantee Fund

Section D: **HIGHER AND FURTHER EDUCATION: Adult**
D1 Adult education

Section E: **MISCELLANEOUS EDUCATIONAL SERVICE, RESEARCH AND ADMINISTRATION; Youth service**
E1 Current expenditure: grants
E2 Capital expenditure: grants

Section F: **MISCELLANEOUS EDUCATIONAL SERVICES, RESEARCH AND ADMINISTRATION: Research and Other services**
F1 The European schools
F2 Teachers on interchange: grants
F3 Organisations concerned with interchange of teachers and students: grants
F4 Joint US–UK educational commission: grants
F5 Miscellaneous services
F6 Educational services and research
F7 Further education unit: grant in aid.
F8 School curiculum development committee: grant in aid.
F9 Secondary examinations council: grant in aid.
F10 Subscriptions to the OECD.
FZ Appropriations is aid.

Section G: **OTHER (NON-PUBLIC) EXPENDITURE: In Service Teacher Training**
G1 Teachers in-service Training.

D

Department of Education and Science

Table	£ million
	1980–81 ———— *1988–89*
CENTRAL GOVERNMENT	
Voted expenditure	
10.1 Schools	
Primary, secondary and other	
Other (supporting services, and fees and non-maintained schools)	
10.2 Higher and further education (including teacher training)	
Universities—capital	
Universities—current	
Voluntary and direct grant—capital	
Voluntary and direct grant—current	
Adult education	
Other student awards	
10.4 Miscellaneous educational services, research and administration	
Youth service—capital	
Youth service—current	
Research and other services—capital	
Research and other services—current	
Administration—capital	
Administration—current	
10.5 Research councils, etc—capital	
Research councils, etc—current	
Total voted expenditure	
Other central government	

E
1985–86, Class X, 1

SCHOOLS, FURTHER EDUCATION AND OTHER EDUCATIONAL SERVICES (DEPARTMENT OF EDUCATION AND SCIENCE)

I **£211,117,000**

Amount required in the year ending 31 March 1986 for expenditure by the Department of Education and Science on schools, further education, teacher training, adult education, miscellaneous educational services and research, including grants in aid and international subscriptions.

The Department of Education and Science will account for this vote.

	£
Net total	211,117,000
Allocated in Vote on Account (HC 8)	85,608,000
Balance to complete	125,509,000

II **SUMMARY AND SUBHEAD DETAIL**

1983–84	*1984–85*	**SUMMARY**	*1985–86*		
Outturn £'000	*Total provision* £'000		*Gross provision* £'000	*Appropriations in aid* £'000	*Net provision* £'000
		Programme 10.1			
		Schools			
37,636	39,300	Section A: Schools capital	51,216	289	50,927
—	1	Section B: School milk subsidy	1	—	1
2,587	2,731	Section C: Direct grant schools	3,035	—	3,035
		Programme 10.2			
		Higher and further education			
97,154	113,930	Section D: Further education and teacher training	118,388	4,297	114,091
12,836	14,526	Section E: Adult education	15,075	—	15,075
		Programme 10.4			
		Miscellaneous educational services, research and administration			
3,209	3,812	Section F: Youth service, etc	4,148	—	4,148
2,153	2,512	Section G: Schools-other grants	2,648	—	2,648
1,626	1,626	Section H: Miscellaneous educational services	1,722	—	1,722
15,899	17,161	Section I: Educational research, etc	19,652	182	19,470
173,100	195,599	Gross total	215,885	4,768	211,117
		Deduct:			
4,397	5,360	Total appropriations in aid	4,768		
168,703	190,239	Net total	211,117		
	Forecast outturn £'000 186,600				

1983–84 Outturn £'000	*1984–85* Total provision £'000	SUBHEAD DETAIL	*1985–86* Provision £'000
		Section A: SCHOOLS CAPITAL	
605	**706**	**A1 Grants to special schools: capital**	**634**
		Grants to non-maintained special schools, usually up to 75 per cent, towards the cost of approved building schemes. There are some 100 eligible schools catering for pupils with special educational needs.	
37,031	**38,594**	**A2 Aided and special agreement schools: building grants and loans.**	**50,582**
	38,094	(1) Building grants. Grants of up to 85 per cent of the cost of repairs and approved capital works to some 4,700 schools. These schools form two of the three categories of voluntary schools (the third being controlled schools) which were established by churches and other voluntary bodies.	50,082
	500	(2) Loans. Discretionary loans to cover the schools' 15 per cent share of certain approved capital works.	500
37,636	**39,300**	Gross total	**51,216**
		Deduct:	
206	**158**	**AZ Appropriations in aid**	**289**
		Repayments of building grants under subhead A2 overpaid in previous years.	
37,430	**39,142**	Net Total	**50,927**
		Section B: SCHOOL MILK SUBSIDY	
	1	**B1 School milk subsidy (net)●**	**1**
		Adjustments arising from payments to local authorities made before Autumn 1981 when the Intervention Board for Agricultural Produce assumed responsibility for the EC School Milk Scheme.	
	2	(1) Payments to local authorities	2
		Less:	
	1	(2) Repayment of subsidy overpaid in previous years	1
		Section C: DIRECT GRANT SCHOOLS	
705	**341**	**C1 Grants to direct grant schools**	**215**
	286	(1) Current	155
		Capitation payments and fee remission in respect of 923 pupils in academic year 1984–85 falling to 207 in 1985–86, when the one grammar school remaining within the scheme becomes maintained. The remaining pupils, at schools which have become independent, attract residual grant. It is expected that by September 1987 all such pupils will have completed their schooling.	
	55	(2) Capital	60
		Grants to cover certain capital debts at the time a school lost its direct grant status.	
1,882	**2,390**	**C2 Grants to music and ballet schools**	**2,820**

	2,215	(1) Current Fee remission and incidental expenses in respect of 435 pupils in academic year 1984–85 and some 515 in academic year 1985–86 at five specialist music and ballet schools.	2,675
	175	(2) Capital Provision covers the cost of capital projects at certain ballet schools.	145
2,587	**2,731**	Total	**3,035**
		Section D: FURTHER EDUCATION AND TEACHER TRAINING	
77,642	**81,510**	**D1 Grants for further education: grant-aided colleges** Grants for current expenditure to 33 colleges, directly funded by the department, including three agricultural and three music colleges. Recurrent costs and expenditure on minor capital works costing £6,000 or less are met from these grants and from tuition fees paid by each student. For the majority of students from England and Wales, tuition fees are paid by local education authorities who receive specific grant from class X, vote 2. For Scottish domiciled students in receipt of awards, fees are paid by the Scottish Education Department from class XV, vote 16. As in previous years these grants also provide approximately £6.5 million for certain costs of catering and residence at 14 voluntary colleges where awards to eligible students (to whom maintenance grant is paid from class X, vote 2) are made at a reduced rate in return for the provision of board and lodging. About 28,500 students are expected in the 1985–86 academic year, 500 more than in 1984–85. Payments in support of the National Advisory Body for Public Sector Higher Education and the Voluntary Sector Consultative Council.	**79,700**
2,456	**3,390**	**D2 Grants and Loans for further education-capital**	**3,068**
	3,358	(1) Grant-aided colleges Grants of up to 100 per cent of the cost of approved capital works and equipment costing more than £6,000. In the case of voluntary colleges amounts paid on building works are normally limited to 85 per cent of the cost. Discretionary loans to cover the Governors' share of the costs.	3,018
	32	(2) Establishments for the handicapped Grants of up to 100 per cent of the cost of approved capital works, for which independent and non-maintained establishments of further education are eligible to apply.	50
727	**1,268**	**D3 Grant-aided colleges: restructuring including redundancies** Grant towards the cost of redundancies and premature retirement compensation arising from restructuring of colleges.	**991**
5,616	5,478	D4 Royal College of Art: grant in aid‡ The Royal College of Art offers postgraduate courses in a wide range of design subjects and the fine arts. The grant in aid meets recurrent expenditure and minor capital works costing less than £20,000. Advice on the level of grant is obtained from a visiting commmittee. The grant also covers expenditure on bursaries for students at the College. 670 students are expected in 1985–86, about 40 more than in 1984–85. An element	5,769

		of this grant—in respect of equipment—may be transferred to a deposit account held by the Paymaster General from which issues will be made as required.	
—	700	**D5 Royal College of Art: grant for capital expenditure** Major capital works at the Royal College of Art's building in South Kensington.	1,558
7,093	7,400	**D6 Cranfield Institute of Technology: grant in aid‡** The Cranfield Institute of Technology provides degree courses in subjects ranging from applied sciences through technology to management. The grant in aid covers recurrent expenditure and minor capital works costing less than £100,000. Advice on the level of grant is obtained from a visiting committee. About 1,500 students are expected in 1985–86, about the same as in 1984–85.	7,561
1,577	1,200	**D7 Cranfield Insitute of Technology: grant for capital expenditure**	416
		Capital projects costing more than £100,000.	416
524	583	**D8 Courses for teachers: grants■** Covers an annual programme organised by Her Majesty's Inspectorate of short in-service training courses and conferences; grant aid for regional courses arranged in consultation with the Department of Education and Science; and bursaries covering travel and accommodation costs of teachers from European countries attending short courses in this country under a scheme run by the Council of Europe. The provision allows for courses involving some 17,000 teachers, the same as in 1984–85.	569
1,117	11,403	**D9 Teachers in-service training ●** Grants to local education authorities in England at rates of 90 per cent of the average salary, superannuation and national costs of teachers in schools and in non-advanced further education released for in-service training on certain courses of varying length in priority training areas. Grants are also paid out at rates of 70 per cent for in-service training in respect of the new GCSE examinations. The provision allows for continuing development of the scheme. Expenditure of £12,700,000 under this subhead is classified as Programme 10.1 (schools).	17,500
402	998	**D10 Teachers training: grants for the training or retraining of teachers in shortage subjects**	1,256
	963	(1) Grants to persons Grants paid through the agency of the Local Government Training Board to persons in England and Wales taking one or two-year courses of initial teacher training or one-year retraining courses. Each award consists of a maintenance allowance (£75 per week in 1984–85) plus payment of tuition fees and additional allowances for dependents, lodgings and travel where appropriate. The provision covers the cost in 1985–86 of final payments to 26 students on the second year of courses beginning in the 1983–84 academic year, plus about 170 awards expected to be made available for courses starting in the 1984–85 academic year and 180 in 1985–86.	1,221
	35	(2) Payments to Local Government Training Board Payments to the Local Government Training Board to cover its costs in administering the scheme.	35
97,154	113,930	Gross total	118,388

		Deduct:	
3,942	4,963	**DZ Appropriations in aid**	4,297
	4,934	(1) Payments by the governments of the Isle of Man and the Channel Islands for higher education students. The island authorities make a contribution in respect of recognised island students attending higher education institutions in the United Kingdom. The home rate of tuition fee is also paid direct to the institutions. Before the 1981-82 academic year the contribution was in respect of teacher training students only. Contributions in respect of an estimated total of 1,315 students only. Contributions in respect of an estimated total of 1,315 students were received in 1984–85.	4,267
	29	(2) Reimbursements from the European Agricultural Guidance and Guarantee Fund. Reimbursement of 25 per cent of the costs of certain vocational training and retraining courses in agriculture and horticulture falling on subhead D1. Expenditure under this subhead is classified as programme 2.7 (Net payments to European Community Institutions).	30
93,212	**108,967**	Net total	**114,091**
		Section E: ADULT EDUCATION	
12,836	14,526	**E1 Adult education**	15,075
	14,459	(1) Current Grants at varying levels up to 100 per cent of the recurrent costs at long-term residential colleges, extra-mural departments of universities, Workers' Educational Association districts and national associations, including the Adult Literacy and Basic Skills Unit. It also incorporates expenditure on adult education bursaries and on the educational needs of unemployed adults. The provision allows for about 460 such awards, slightly more than in the 1984–85 academic year. The provision also includes grants to the TUC and non-affiliated unions for the education and training of trade union and health and safety representatives: a similar grant is also made by the Department of Employment (class IV, vote 13).	15,015
	67	(2) Capital Grant towards major roof repair at Ruskin College.	60
		Section F: YOUTH SERVICES, ETC	
2,849	3,312	**F1 Current expenditure: grants** Grants to two organisations for training youth leaders; to the National Youth Bureau for information and training services; grants towards the administrative expenses of the headquarters and the educational aspects of the work of some 65 to 70 national voluntary youth organisations; for miscellaneous development and experimental projects and a grant to the British Youth Council for the co-ordinating and planning of the International Year of Youth in England (1985).	3,628
360	500	**F2 Capital expenditure: grants** Grants towards capital projects of national or regional significance carried out by the voluntary youth service. The number of new projects will depend on the number of applications, but is expected to be about 12.	520
3,209	**3,812**	Total	**4,148**

		Section G: SCHOOLS—OTHER GRANTS	
1,455	1,567	**G1 The European schools**	1,682
		United Kingdom contribution in respect of salaries, etc of British teachers in the English language sections of the schools established under the statute of the European Schools, primarily providing for children and staff of European Community institutions: these schools include one at Culham, Oxfordshire. Expenditure on the premises of the Culham School is met by the Property Services Agency (class XIV, vote 3)	
698	945	**G2 Teachers on interchange: grants■**	966
		Grants to teachers in England and Wales on study visits and exchange schemes in other countries. The provision allows for about 580 full-year exchanges in 1985–86 (580 in 1984–85). Actual take-up in 1984–85 is expected to be about 400 full-year exchanges.	
	294	(1) League for the Exchange of Commonwealth Teachers	301
	651	(2) Central Bureau for Education Visits and Exchanges	665
2,153	2,512	Total	2,648
		Section H: MISCELLANEOUS EDUCATIONAL SERVICES	
1,448	1,371	**H1 Organisations concerned with the interchange of teachers and students: grants**	1,411
		The administration expenses of the Central Bureau for Educational Visits and Exchanges (CBEVE) and the League for the Exchange of Commonwealth Teachers for activities including those described in subhead G2 and also information and other services provided by CBEVE in support of education visits and exchanges.	
175	246	**H2 Joint United States–United Kingdom Commission: grants§■**	292
		The sterling equivalent of one third the cost of administering the Fulbright Scholarships and Student Awards. The United States government meets the remaining two thirds.	
3	9	**H3 Miscellaneous Services**	19
	2	(1) Education of Poles in England and Wales. Allowances are paid to children aged 5 and over of Polish disabled ex-servicemen who served with HM Forces during the 1939–45 war. Payments are made by the Department of Health and Social Security who are reimbursed by the DES at the end of each financial year. It is estimated that payments will be made to Social Security who are reimbursed by the DES at the end of each financial year for international conferences held in England and Wales which are considered to be of special value to the education service. Between five and ten conferences are expected to be supported in 1985–86 compared with five in 1984–85.	2
1,626	1,626	Total	1,722
		Section I: EDUCATIONAL RESEARCH ETC	
10,052	11,438	**I1 Educational Services and Research**	12,483
	11,113	(1) Grants and other payments for educational services and research. The Department's research budget, estimated at about £2.7 million, is expected to finance about 74 research and development projects in all areas of education (compared with about 65 in 1984–85). In addition, grants totalling about £9.4 million are to be	12,145

paid to about 40 private non-profit making bodies that have special services to offer the education field (compared with about 40 in 1984–85). The largest grants are for the National Development Programme in Microelectronics in Education, for work on the Educational Counselling and Credit Transfer Information Scheme to the Council for Educational Technology in the United Kingdom, and for the Department's PICKUP programmes.

	254	(2) Research work commissioned from local education authorities and other institutions in the United Kingdom, including payments to local education authorities in respect of DES's share of the cost of EC pilot projects on education and employment.	268
	71	(3) Expenses of special experimental work in education methods, school building etc.■	70
2,066	3,332	**I2 Further Education Unit: grant-in-aid‡■** This unit supports investigations of, and experimentation in, the development and review of further education curricula. The Unit's basic grant-in-aid to undertake this work is £2.154 million. In addition, the Department has commissioned the Unit to give support to a number of the Department's own programmes including PICKUP (£0.729 million), REPLAN (development of education opportunities for the adult unemployed—£0.207 million) and the Certificate of Pre-vocational Education (£0.555 million)	3,645
1,150	1,000	**I3 School Curriculum Development Committee: grant-in-aid‡** This Committee is an independently constituted body funded equally by the Government and the Local Authority Associations to promote and support curriculum development relevant to needs of school education in England and Wales.	1,053
850	1,288	**I4 Secondary Examinations Council: grant-in-aid‡** This Council is wholly funded, and its members are appointed, by the Government. Its function is to oversee, monitor and advise the Government on examinations offered to pupils during the years of compulsory schooling and at 18+ and to engage in research necessary in support of these activities. The subhead includes £825,000 to support a programme of teacher training for the introduction of the General Certificate of Secondary Education and preparation of supplementary national criteria for prevocational courses offered to pupils during the years of compulsory schooling.	2,341
101	103	**I5 Subscriptions to the Organisation for Economic Co-operation and Development§** Expenses for the specific programmes below are met by subscriptions from the member states. Provision in each case is made for the final three-quarters of the calendar year ending 31 December 1985 and the first quarter of the calendar year ending 31 December 1986.	130
	68	(1) Centre for Educational Research and Innovation. The UK share of the cost is expected to be about 1,030,000 French francs.	90
	35	(2) Educational building programme. The UK share of the cost is about 22.63 per cent, 455,500 French Francs. Membership extended, by renewal of mandate, to 31 December 1988.	40

1,680	—	*Schools Council: grant-in-aid* *The costs of closure relating to the Schools Council are now met from class X, vote 2 subhead D3.*	
15,899	**17,161**	Gross total	**19,652**
		Deduct:	
249	**239**	**IZ Appropriations in aid**	**182**
	110	(1) Payment from Department of Education for Northern Ireland towards five research projects sponsored by the Assessment of Performance Unit (APU) of the DES.	73
	129	(2) Payment from Welsh Office Education Department towards six research projects sponsored by the APU of the DES.	93
	—	(3) Payment from Manpower Services Commission towards cost of Open University project developing learning materials for the unemployed.	16
15,650	**16,922**	Net total	**19,470**

III EXTRA RECEIPTS PAYABLE TO THE CONSOLIDATED FUND

1983–84	*1984–85*		*1985–86*
£'000	*£'000*		*£'000*
		In addition to the appropriations in aid there are the following estimated receipts:	
3,580	3,766	(1) Repayment of loans and interest by aided and special agreement schools, etc.	3,868
62	195	(2) Sale of land and property	2
273	142	(3) Miscellaneous	9
3,915	4,103		3,879

IV ANALYSIS OF THE VOTE BY PROGRAMME AND TYPE OF EXPENDITURE: 1985–86

	Nature of expenditure				*£'000*
Programme	*Public expenditure*			*Other*	*Total*
	Current	*Capital*	*Total*		
2.7 Net payments to the European Community Institutions	−30	—	−30	—	−30
10.1 Schools	2,975	50,987	53,962	12,701	66,663
10.2 Higher and further education	106,594	5,102	111,696	4,800	116,496
10.4 Miscellaneous educational services, research and administration	27,468	520	27,988	—	27,988
Total	137,007	56,609	193,616	17,501	211,117

F

3.10 EDUCATION AND SCIENCE

TABLE 3.10

£ million

	1979–80	*1980–81*	*1981–82*	*1982–83*	*1983–84*[1]	1984–85[2]	1985–86	1986–87	1987–88
Department of Education and Science									
10.1 Schools									
Under fives									
Local authority capital[3]	10	9	17	14	13	12	12	10	10
Local authority current	177	222	241	274	300	320	332	350	*
Primary, secondary and other									
Central government capital	36	37	40	35	34	36	37	40	40
Local authority capital	276	338	244	257	243	190	183	190	190
Primary									
Local authority current	1,706	2,086	2,258	2,349	2,430	2,535	2,564	2,680	*
Secondary									
Local authority current	2,354	2,952	3,304	3,544	3,740	3,880	3,901	4,000	*
Special schools									
Local authority current	249	309	347	382	415	420	404	420	*
Other (supporting services, and fees at non-maintained schools)									
Central government current	9	8	9	12	18	25	34	40	50
Local authority current	137	157	178	191	195	200	204	210	*
Transport									
Local authority current	136	160	174	184	195	200	198	200	*
Meals and milk									
Local authority current	422	397	396	411	430	415	280	280	*

TABLE 3.10 *(continued)*

£ million

	1979–80	*1980–81*	*1981–82*	*1982–83*	*1983–84*[1]	1984–85[2]	1985–86	1986–87	1987–88
10.2 Higher and further education (including teacher training)[4]									
Universities									
Central government capital	105	115	120	121	118	127	134	140	140
Central government current	785	1,013	1,043	1,258	1,306	1,339	1,371	1,410	1,440
Non-Universities									
Local authority capital	75	107	84	115	87	68	66	70	70
Maintained sector advanced									
Local authority current	390	454	503	609	635	640	630	660	*
Maintained sector non-advanced (except adult education)									
Local authority current	546	688	790	878	940	965	868	850	*
Voluntary and direct grant									
Central government capital	2	2	3	4	4	5	5	10	10
Central government current	61	79	82	90	93	98	98	100	100
Adult									
Central government current	7	8	10	11	13	14	15	20	20
Local authority current	56	61	67	77	85	90	61	80	90
Mandatory student awards									
Local authority current	534	663	770	669	734	706	704	700	720
Other student awards									
Central government current	5	5	6	6	4	4	4		
Local authority current	84	95	107	121	130	140	132	140	*

TABLE 3.10 *(continued)*

£ million

	1979–80	*1980–81*	*1981–82*	*1982–83*	*1983–84* [1]	1984–85 [2]	1985–86	1986–87	1987–88
10.4 Miscellaneous educational services, research and administration									
Youth service									
Central government capital	2	2	1	1			1		
Central government current	2	2	2	3	3	3	4		
Local authority capital	7	6	5	10	7	6	7	10	10
Local authority current	64	76	86	97	105	110	104	120	*
Research and other services									
Central government capital	2	2	1						
Central government current	8	11	14	15	19	21	24	20	20
Local authority capital	5	12	12	16	5	4	5		
Local authority current	33	36	41	46	50	50	47	50	*
Administration									
Central government capital					1	2	2		
Local authority current	298	367	405	435	485	525	534	570	*
Central government current	23	28	31	32	44	48	50	50	50
Total education									
Central government capital	150	161	168	165	161	175	183	190	200
Central government current	899	1,154	1,198	1,427	1,500	1,552	1,601	1,650	1,700
Local authority capital	373	472	362	413	355	280	272	280	290
Local authority current	7,185	8,722	9,666	10,267	10,869	11,196	10,963	11,310	11,450
Total education	8,608	10,509	11,393	12,273	12,885	13,203	13,019	13,430	13,630

TABLE 3.10 *(continued)*

£ million

	1979–80	*1980–81*	*1981–82*	*1982–83*	*1983–84* [1]	1984–85 [2]	1985–86	1986–87	1987–88
10.5 Research councils, etc									
Central government capital	63	71	71	77	76	79	76	70	70
Central government current	277	322	380	405	441	471	508	530	540
Total science	340	393	451	482	516	550	584	600	610
Total education and science									
Capital	585	702	598	650	588	529	527	540	550
Current	8,360	10,198	11,243	12,100	12,809	13,219	13,071	13,480	13,680
Total programme	8,945	10,899	11,841	12,750	13,398	13,748	13,598	14,020	14,240

*See paragraph 8.
(1)The 1983–84 figures incorporate a distribution by sector of total current spending by local authorities based on their provisional outturn expenditure on education.
(2)The 1984–85 figures incorporate a provisional distribution by sector of total current spending by local authorities based on their budgets.
(3)From 1981–82 the under fives capital expenditure includes provision for the urban programme.
(4)The change in the trend of higher education and student awards figures between 1981–82 and 1982–83 reflects the reduction in tuition fees described in Cmnd 8494.

TABLE 3.10.1

Analysis by broad economic category

£ million

	1979–80	1980–81	1981–82	1982–83	1983–84	1984–85	1985–86
Pay	5,314	6,575	7,303	7,788	8,300	8,564	8,568
Other current expenditure on goods and services	1,269	1,403	1,518	1,732	1,771	1,864	1,649
Subsidies and current grants	1,777	2,219	2,422	2,580	2,738	2,791	2,853
Total current expenditure	8,360	10,198	11,243	12,100	12,809	13,219	13,071
Gross domestic fixed capital formation	413	514	411	461	399	328	315
Capital grants, loans, etc	172	188	187	189	189	201	211
Total capital expenditure	585	702	598	650	588	529	527
Total programme	8,945	10,899	11,841	12,750	13,398	13,748	13,598

1. The programme covers those areas which are the responsibility of the Secretary of State for Education and Science. Tables 3.10 and 3.10.1 show the programme by spending authority and broad economic category. About three-quarters of the programme is current expenditure by local authorities in England, principally on schools, but also on institutions of higher and further education, and the youth service. The remaining quarter of the programme is expenditure by central government, mainly on universities in Great Britain, voluntary and direct grant colleges in England, civil science in the UK, and student awards in England and Wales. Eighty per cent is subject to cash limits: the largest part not subject to cash limits relates to student awards.

Education

AIMS AND OBJECTIVES

2. The general purpose of the Government's education policies is to ensure that the resources which can be made available to the education service are spent to the maximum benefit of all pupils and students and hence of the nation as a whole. The Government is concerned to raise standards of achievement for all levels of ability throughout all parts of the education system. The quality of resources, including teaching resources, deployed in the service and the effectiveness with which they are used are crucial to the achievement of these aims.

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THIRD STANDING COMMITTEE ON STATUTORY INSTRUMENTS, &c.

MINUTES OF PROCEEDINGS ON THE

DRAFT SUMMER TIME ORDER 1985

Ordered by The House of Commons *to be printed*
27th November 1985

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THIRD STANDING COMMITTEE ON STATUTORY INSTRUMENTS, &C.

DRAFT SUMMER TIME ORDER 1985—Referred to a Standing Committee on Statutory Instruments &c. on 11th November 1985; allocated by Mr. Speaker to the Third Standing Committee on Statutory Instruments, &c. on 13th November.

The Committee was constituted as follows:—

Mr. JOHN FORRESTER appointed Chairman, 14th November

Mr. David Amess
Mr. Gerald Bermingham
Mr. Sydney Bidwell
Mr. Michael Carttiss
Mr. Harry Cohen
Mr. Robin Corbett
Mr. James Couchman
Mr. Tony Favell
Mr. George Gardiner
Dr. Keith Hampson
Mr. Gwilym Jones
Mrs. Elaine Kellett-Bowman
Mr. Max Madden
Mr. Michael Meadowcroft
Mr. David Mellor
Mr. Ian Mikardo
Mr. Michael Neubert
Mr. Patrick Nicholls

PROCEEDINGS OF THE COMMITTEE

Wednesday 27th November 1985

MEMBERS PRESENT

Mr. JOHN FORRESTER in the Chair

Mr. David Amess
Mr. Michael Carttiss
Mr. Robin Corbett
Mr. James Couchman
Mr. Tony Favell
Mr. George Gardiner
Mr. Gwilym Jones
Mr. David Mellor
Mr. Ian Mikardo
Mr. Michael Neubert
Mr. Patrick Nicholls

DRAFT SUMMER TIME ORDER 1985

Resolved, That the Committee has considered the draft Summer Time Order 1985.—(*Mr. David Mellor.*)

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SOCIAL SERVICES FOR CHILDREN IN ENGLAND AND WALES 1982–84

A report by the Secretaries of State for Social Services and for Wales with respect to the exercise by local authorities of the functions specified in Section 79(5) of the Child Care Act 1980, the provision by voluntary organisations of facilities for children, and other matters relating to children.

Required by Section 79(4) of the Child Care Act 1980 to be laid before Parliament.

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SOCIAL SERVICES FOR CHILDREN
IN ENGLAND AND WALES, 1982–84

INTRODUCTION

This is the fourth report by the Secretaries of State for Social Services and for Wales on social services for children, and it covers the period 1982 to 1984. Such reports are required every third year under Section 79(4) of the Child Care Act 1980. The content is prescribed by Section 79(5) which specifies certain services for children provided by voluntary organisations. The first report was published on 21 December 1976 and covered the years 1973 to 1975, the second was published on 26 November 1979 and covered the years 1976 to 1978 and the third was published on 15 December 1982 and covered the years 1979 to 1981. The format adopted in this report is broadly similar to that of the earlier reports. Throughout the report, the word "children" is used to describe children and young persons under the age of 18, and those who have attained that age and are still the subject of a care order. Figures given in tables are from DHSS statistics unless otherwise stated. All 1984 statistics are provisional. Figures may not always add to totals because of roundings

CHAPTER 1

FRAMEWORK WITHIN WHICH SERVICES FOR CHILDREN WERE PROVIDED

THE STATUTORY STRUCTURE

1. The main legislation for the provision of services for children remained relatively unchanged during the period covered by this report. There were, however, a number of important legislative developments during the period designed to strengthen or expand the range of services available for children to enhance their protection and to provide additional rights for parents and children.

The Children Act 1975

2. All the provisions of Part I of the Act are now in force with the exception of sections 1 and 2 which impose a duty on each local authority to establish and maintain an adoption service. Nearly all local authorities already provide this service to some extent, either themselves or through an approved adoption society. The Government has confirmed its wish to bring in these provisions when possible. The provisions of Part I brought into force in May 1984 were described in the Children Act 1975—Second Report to Parliament. (HoC Paper 20–1984).

3. Part II of the Act which provides for custodianship orders was brought into force on 1 December 1985. This will enable relatives (including step-parents) and others (including foster parents) who have cared for a child to apply to a court for legal custody. It also empowers courts to treat an application for adoption as if it were an application for custodianship where that would be in a child's best interest. Custodianship will give local authorities a new option in planning for children in care.

4. Part III of the Act contains a series of child care provisions, the remainder of which came into force for England and Wales during the currency of this Report. They were described in the Children Act 1975—Second Report to Parliament as follows:—

> The remainder of Section 64 (separate representation of children and parents in care proceedings)—paragraphs 41,69 and 70 refer.
>
> Section 58 (part)—(now Section 7 of the Child Care Act 1980) (making the child a party in parental rights-related proceedings)—paragraph 71.
>
> Section 60 (now Section 64 of the Child Care Act 1980) (vesting of parental rights and duties in voluntary child care organisations)—paragraph 84.
>
> Regulations under Section 103 (panels of guardians *ad litem* and reporting officers safeguarding the interests of children in care, care related and adoption proceedings)—paragraphs 73–74.

The Children's Homes Act 1982

5. The Children's Homes Act 1982, which has not yet been implemented, provides for a scheme of registration and inspection of privately-run children's homes which accommodate children who are in the care of local authorities. The registering authority will be the local authority for the area in which the home is situated. It is expected that the Act, as amended by the Health and Social Services and Social Security Adjudications Act 1983, will be brought into force in 1986, together with Regulations governing the conduct of these homes and the services and facilities to be provided.

The Criminal Justice Act 1982

6. Part I of the Criminal Justice Act 1982, which made substantial changes to the sentencing provisions relating to young offenders, was brought into force on 24 May 1983. Sections 26–28 of the Act, which dealt with financial sanctions against parents and guardians, were brought into force on 31 January 1983. The main features of the Act affecting children were:—

(a) the abolition of the sentence of borstal training and the introduction of the determinate sentence of youth custody exceeding 4 months but not more than 12 months for juvenile offenders aged 15 and over,

(b) provision for determinate detention centre orders of not less than 21 days nor more than 4 months for male juvenile offenders aged 14 and over,

(c) a requirement that the court should not impose a detention centre order or sentence of youth custody unless no other sentence is appropriate on one of three specified grounds,

(d) providing the court with an increased range of community-based options for dealing with juvenile offenders through new powers in making supervision orders with requirements,

(e) the introduction of additional criteria that must be satisfied before a court makes a care order under section 7(7) of the Children and Young Persons Act 1969 (enabling care orders to be made in criminal proceedings),

(f) a new power to add to a care order a condition as to the charge and control of offenders in care who re-offend,

(g) the introduction of community service orders for offenders age 16, and

(h) provisions for strengthening the safeguards surrounding the placement of children in care in secure accommodation in community homes.

The Health and Social Services and Social Security Adjudications Act 1983

7. Section 4 of the 1983 Act made changes to the statutory arrangements for the provision of residential care for children so as to create a more flexible framework and these are explained in paragraphs 23 to 27 below.

8. Section 19 of the 1983 Act made certain changes to the legislation on charges for children in care and came into force on 1 January 1984. In

particular, all young people in care on reaching the age of 16 become liable for contribution towards their maintenance; parents are exempt from liability for contributions for under 16s if the parents are in receipt of supplementary benefit or family income supplement; local authorities are given power to waive contributions where they consider it unreasonable in the particular circumstances to collect them; and local authorities now have power to charge a flat rate contribution for all children in their care as an alternative to a means tested contribution.

9. Schedule 1 to the 1983 Act introduced a new Part IA into the Child Care Act 1980 governing access to children in care. A description of the new provisions and the statutory Code of Practice on access to children in care is given in paragraphs 70 to 73 below.

10. A number of other miscellaneous changes to child care law were incorporated in Schedule 2 to the 1983 Act. Some of these are described in the Children Act 1975—Second Report to Parliament, in paragraphs 79, 85 and 86. Most of the changes were minor or technical in nature.

The Child Abduction Act 1984

11. The Child Abduction Act 1984 came into force on 12 October 1984 and Part I extends to England and Wales. The Act replaces the old offence of child stealing with two new offences: one to deal with the abduction of a child from the United Kingdom by a parent or other person similarly connected with the child; the other to deal with abduction by a person not connected with the child. The Schedule to the Act makes modification to the Act in respect of children in care and other special categories where the provisions of child care, adoption and custodianship legislation already apply. Broadly speaking it ensures that "appropriate consent" to the taking or sending of such a child out of the UK is required from the local authority, voluntary organisation or court involved. It reflects the safeguards already in child care legislation concerning the unlawful removal of these vulnerable groups of children.

The Registered Homes Act 1984

12. Part III of the Registered Homes Act 1984, which came into force on 1 January 1985, provides for the setting up of Registered Homes Tribunals to hear appeals against decisions of registering authorities in respect of, *inter alia,* voluntary children's homes registered under the Child Care Act 1980, and privately-run children's homes registered under the Children's Homes Act 1982 when it is implemented.

The Child Abduction and Custody Act 1985

13. The Child Abduction and Custody Act 1985, which will come into force in the first half of 1986, enables the United Kingdom to ratify and implement two international conventions. Part I of the Act gives effect in the UK to the Hague Convention of 1980 on the Civil Aspects of International Child Abduction. This Convention provides for the expeditious return of children to the country of their habitual residence who are wrongfully removed to or kept in another contracting State. Part II of the Act gives effect

in the UK to the European Convention of 1980, which is complementary to the Hague Convention and covers cases where there has already been a court decision on the custody of a child. In a case in which both Conventions apply the Hague Convention will prevail.The Lord Chancellor's Department will act as the Central Authority required by both Conventions, but individual cases will be heard by the High Court. There is provision for welfare reports to be obtained from a local authority or probation officer, and for all other non-criminal proceedings concerning the child to be held in abeyance until the application under the Convention is heard. The High Court is empowered to give interim directions safeguarding the child's welfare pending the final hearing. If the High Court decides to make an order returning the child (or enforcing the decision of a foreign court, if different) any existing custody order in the UK automatically ceases to have effect.

THE SECOND REPORT FROM THE SOCIAL SERVICES COMMITTEE (SESSION 1983/84—CHILDREN IN CARE) AND GOVERNMENT'S RESPONSE

14. In July 1982 the Social Services Select Committee in the last Parliament decided to undertake an inquiry into children in care. Between November 1982 and May 1983 they heard evidence and made visits to various agencies in the UK and abroad. Shortly afterwards Parliament was dissolved but the Committee was established subsequently in December 1983 when they decided to take up and complete the work of their predecessors. The report of the Committee[1] was published in April 1984—it made 108 recommendations on policy and practice in the child care field. The Government published its response[2] to the Select Committee report in July that year. In response to one of the recommendations of the Committee, the Government announced the setting up of an inter–Departmental working party in association with the Law Commission to codify and review child care law (see paragraph 15 below). A number of other recommendations are being followed up by Government; others are directed at local authorities, the Central Council for Education and Training in Social Work and other bodies and have where appropriate been drawn to their attention. References to the Select Committee report will be found in other sections of this Report.

THE REVIEW OF CHILD CARE LAW

15. As recommended by the Social Services Select Committee (see paragraph 14 above) DHSS established a working party to review child care law with a view to the production of a simplified and coherent body of law. The review was to go beyond questions of legal technicalities but fall short of a fundamental examination of child care practices as such. The inter-departmental working party was commissioned "to make proposals and set out options for codification and amendment of child care law" in the light of the Select Committee report, evidence given to the Committee and other relevant material. The working party reported to Ministers in July 1985.

[1] Second report from the Social Services Committee, 1983/84 Session. Children in Care. H of C paper 36. 1984.

[2] Government response to the second report from the Social Services Committee 1983/84. Cmnd 9298. HMSO 1984.

Their report was published as a consultative document in October 1985 and comments invited by January 1986.

SERVICES PROVIDED BY LOCAL AUTHORITIES

Finance

16. Not all spending on children's services is separately identified in local authority expenditure returns. Spending on social work, for example, is not split between client groups and it is not therefore possible to show how much of the total is spent on children's services. Figures for the elements which are separately identified are given in the following table, which reflect the increased emphasis given to the further development of boarding out (described in paragraph 49 below) and the decline in residential provision for children (described in paragraphs 51–52 below).

Gross current expenditure in England and Wales. £ million in 1983/84 cost terms (including health authority contributions to jointly financed projects)—Table 1.1

	1981/82	1982/83	1983/84
Residential care	374.9	355.7	328.8
Boarding out	68.2	76.2	81.3
Preventive work with families	7.1	8.3	10.1
Day Care centres	4.7	5.6	6.5
Intermediate treatment	9.7	11.8	13.9
Day nurseries	78.3	80.5	82.7
Pre-school playgroups	6.4	6.5	7.2
Total identified children services	549.3	544.6	530.5
All personal social services	2528.2	2599.1	2679.0

17. Most local authority spending on children's services, as with all personal social services spending, is financed by rate income or rate support grant. Local authorities are free to decide for themselves the level of spending on children's services, taking account of local circumstances and priorities and of the Government guidelines regarding their total all-services expenditure. For 1983/84, expenditure on personal social services was financed as follows:

	£ million (cash)
Rates and rate support grant	2,206.8
Specific grants	38.8
Fees and charges income	380.3
Health authority contributions	53.1
	2,679.0

The Urban programme

18. Central Government continues to make a 75% grant towards projects supported under the Urban Programme aimed at helping inner city areas to combat problems of severe urban deprivation. The total programme is about £350 million a year, of which about £100 million is spent on social projects covering educational, social services, health and recreational schemes. A large part of this is devoted to projects to benefit children who are at risk of

harm or getting into trouble, or need special help because they are mentally or physically handicapped. Single parent families, the under fives and children from ethnic groups are given high priority. The Programme is divided into three parts; Partnership and Programme authorities which are areas of the most acute need, and the "Traditional Urban Programme" (TUP) which covers all other urban areas of special need. DHSS supports projects to the value of about £10 million a year under the TUP, and typical of these are day nurseries, after-school children's clubs, battered wives and children's refuges, intermediate treatment projects, family youth and community centres and respite care schemes for mentally handicapped children. In addition about £¾ million a year is granted for holiday projects for deprived children. The Urban Programme in Wales is operated by the Welsh Office. In 1984/85 allocations amounted to over £22 million of which £8.6 million was aimed specifically at projects of a social nature. These included schemes similar to those supported by the DHSS. In addition over £300,000 was set aside to assist authorities in providing holidays, play schemes and other activities during the Easter and Summer school holidays.

MANPOWER

19. The number of staff employed by local authority social services departments in England and Wales at 30 September 1982 was 302,786 and at 30 September 1984 was 313,598. These figures are somewhat higher than the whole-time equivalents shown in the table below as approximately 61% of staff are employed part-time. Except for certain types of residential provision it is not possible to isolate the staff resource deployed in children's work from overall social services department staff numbers.

Staff employed by Local Authority Social Services Departments at 30 September by category—Table 1.2

Full-Time Equivalent (thousands)

England and Wales	1982	1983	1984
Senior directing, managing, professional and advisory staff	4.3	4.5	4.8
Qualified and Unqualified field social workers	24.3	25.1	25.7
Administrative and Clerical	14.7	14.8	15.0
Staff of community homes	21.5	20.9	19.1
Staff of day nurseries	8.7	9.0	9.0
Staff of part-time nursery groups	0.2	0.2	0.2
Staff of homes for the younger physically handicapped	1.5	1.6	1.6
Staff of homes for mentally handicapped children	2.3	2.5	2.6
Other SSD staff	137.7	143.7	147.4
Total	215.2	222.3	225.4

TRAINING

20. The Central Council for Education and Training in Social Work (CCETSW) was set up in 1971 and given responsibilities for developing qualifications in social work and for the maintenance of standards on courses leading to such qualifications. Its two qualifying awards are the CQSW (certificate of qualification in social work) and CSS (certificate in social service). The establishment of the CSS in 1975 signified CCETSW's acceptance of responsibility for qualifying training for wider groups of social services

staff. The CSS is a work-based course for which students are released part-time by their employers. In 1981 CCETSW set up a review of qualifying training. The outcome of this review was a recommendation for a unified system of qualifications in social work with one award only. There would be two routes to this award, one college based, and one employment based. Further details have still to be worked out and the proposed changes will take some time to implement.

SERVICES PROVIDED BY VOLUNTARY ORGANISATIONS

21. The Government believes that voluntary organisations can offer a flexible and innovative approach, extending choice and variety of provision, particularly in experimental or specialised services. They also provide a framework which encourages greater community participation, whether by involvement as volunteers or by participation in self-help or mutual aid activities.

22. The total value of grants to voluntary organisations continues to rise from £15.5 million in 1982/83 to £30 million in 1984/85. This is a result of increases in existing budgets such as that for the general scheme of grants under Section 64 of the Health Services and Public Health Act 1968, which is used for Headquarters and administrative expenses of national voluntary organisations, and by the introduction of specific schemes designed to encourage particular sorts of provision. Examples of the latter include the Under Fives initiative and the Intermediate Treatment initiative, both referred to elsewhere (see paragraphs 31 and 80–83 below).

CHILDREN'S REGIONAL PLANNING COMMITTEES AND COMMUNITY HOMES

23. The Children and Young Persons Act 1969 required local authorities to set up children's regional planning committees (RPCs) to plan the provision of community homes for children in the care of local authorities in their region and to produce regional schemes of intermediate treatment (IT) facilities for use by children and young people on supervision orders with IT requirements. The committees were established in 12 regions on 1 April 1973.

24. The Criminal Justice Act 1982 (the relevant provisions of which came into effect on 24 May 1983) effectively transferred the responsibility for producing IT schemes from RPCs to local authorities either on their own or in conjunction with other local authorities. It also added the requirement that such schemes should be produced in consultation with the local probation service.

25. As the community home system developed many local authorities became self-sufficient or nearly self-sufficient in meeting residential needs for children in their care. The continued need for regional planning of community homes became less. Although it was envisaged that in some areas there would be a continuing need for collaboration between local authorities in the provision of community homes to meet their mutual needs often this was not needed on a regional basis. Two or three adjacent local authorities, not

necessarily part of the same region, might co-operate together in some areas whilst in others the regional planning structure might continue to be more appropriate, as in London for example.

26. There had been an increasing emphasis on placing children in care in community homes near their own homes. This helped children to maintain links with their families and enhanced the prospects of an early return home where appropriate. More local placements also made possible more intensive work with families to take place in preparation for the child's return home. It also enabled integrated programmes to be designed comprising shorter periods of residential care and periods of close supervision in the community. As a result more community homes began to develop such integrated programmes, providing both the residential and non-residential components. The use of more remote residential establishments lessened.

27. In line with these changing circumstances the Health and Social Services and Social Security Adjudications Act 1983:

(a) abolished the statutory requirements for children's regional planning, replacing this with a permissive power for local authorities to combine with others, if they thought fit, to plan to meet their joint needs for community homes,

(b) placed a duty on local authorities to make such arrangements as they thought appropriate—on their own or jointly—for ensuring that community homes were available for children in their care,

(c) widened the use to which community homes could be put to include use for children not in care but for whom local authorities had welfare responsibilities (eg. under Section 1 of the Child Care Act 1980 or for intermediate treatment), and

(d) required local authorities, as far as practicable, to place children in their care in accommodation near to their homes.

These provisions came into effect on 1 January 1984. Circular LAC (83)20 (Welsh Office Circular 8/84) explained the changes.

CHAPTER 2

SERVICES FOR CHILDREN IN THEIR HOMES

PREVENTIVE SERVICES

28. It is recognised that services which help support families in caring for their children play a crucial part in reducing the need for children to come into local authority care. Families are supported by a large number of agencies which help with housing, education, health care and income support. Social Services Departments, however have a specific preventive function in that they have a duty under Section 1 of the Child Care Act 1980 to promote the welfare of children by diminishing the need for them to come into care, to be kept in care or to be brought before the courts. Cash payments may exceptionally be made under this provision but form only a small part of the total expenditure of local authorities on preventive services. These include intensive field social work to support individual children and families and the provision of day and family services. The DHSS and Welsh Office place a priority on the provision of preventive services and recognise the progress and useful work carried out by many local authorities in conjunction with voluntary agencies and self-help groups.

29. The net expenditure of local authorities in England and Wales on preventive services under Section 1 of the 1980 Act was just over £3.5 million in 1982/83 and some £4 million in 1983/84.

DAY CARE FOR PRE-SCHOOL CHILDREN AND FAMILY SUPPORT

30. Local authorities provide day care and family support services for families with particular health or social needs, as well as registering private day nurseries, playgroups and childminders. Many authorities further developed their role in advising and supporting registerable services provided in the voluntary and private sectors. At central government level, the Inter-Departmental Consultative Group on Under Fives continued to meet periodically with the local authority associations, the National Association of Health Authorities and voluntary organisations, to consider matters of common interest. Following the report of the Home Affairs Select Committee on racial disadvantage[3], the Consultative Group in agreement with the other organisations set up in 1982 an independent sub-group drawn from central government, the local authorities, the Commission for Racial Equality and voluntary bodies to consider services for under-fives from ethnic minority communities. The Sub-group's report was published in November 1984 and was given a wide free distribution to statutory authorities, community relations councils and voluntary organisations including local groups from minority communities. Child Care (the National Council for Voluntary Child Care Organisations) agreed to arrange a series of regional seminars at which the report's recommendations could be discussed in local contexts.

[3] Fifth Report from Home Affairs Committee—Session 1980/81—HC424

Under-fives Initiative

31. In October 1983, DHSS launched a centrally financed initiative to stimulate voluntary sector provision for disadvantaged families with pre-school children. Six million pounds was made available over a period later extended to March 1987 to fund selected voluntary projects aimed particularly at assisting one parent families; two parent families where family income was low; isolated parents at home with young children; and disadvantaged ethnic minority families where difficulties may be increased by language and cultural differences. Fourteen major voluntary organisations undertook the overall management of a programme of some 80 projects while Child Care managed the funding of 30 more projects developed by small local groups unaffiliated to major voluntary bodies. The programme encompassed relevant provision of all kinds, including childminding support, day nurseries, family centres, volunteer home-visiting, playgroups, play buses and toy libraries. DHSS advanced some £650,000 to participating agencies in 1983/84 and expenditure in 1984-1985 amounted to £1.9 million. A similar initiative was introduced in Wales in 1985/86 with £300,000 being made available over a three year period.

Day Services

32. Table 2.1 shows that the number of day nursery places provided by local authorities remained broadly steady at about 29,000 between 1982/84. In that time the number of private and voluntary places increased by 10.3% from 21,874 to 24,130 and the number of registered childminders rose substantially by 20.1% with the places available increasing also by 20.1%. The number of registered playgroups rose by 7.4% to 16,511 and the number of places overall in registered playgroups rose by 4.6% to 403,244. Many local authorities continued to develop more flexible services for under-fives with parental involvement through family day centres and to support and encourage a wider range of services provided through voluntary organisations and community initiatives, including drop-in facilities, playgroups and mother and toddler clubs, parent support groups, community nurseries, toy libraries and volunteer home visiting. Schemes for the care of children out of school hours and during holidays have also developed considerably, particularly as a result of voluntary or self-help initiatives. In 1984 DHSS announced its intention to review the longstanding legislation and guidance covering day services.

33. Substantial central government grant-aid was made available to national voluntary organisations dealing specifically with families with under-fives. Grant-aid under this head included support for the Pre-school Playgroups Association in England and Wales, Mudiad Ysgolion Meithrin (The National Association of Welsh Medium Nursery Schools and Playgroups) and the National Childminding Association. Grants for these organisations rose from £570,750 in 1982/83 to an agreed £710,520 in 1984/85, an increase of 24.5%. In 1982 DHSS began funding the Home-Start Consultancy, which advised volunteer home-visiting schemes within the

Home-Start movement and other under-fives organisations were also grant-aided during this period.

Day Care Provision for Children under five—Table 2.1

(thousands)

England and Wales	1982	1983	1984
Day Nurseries			
Places in local authority day nurseries	28.6	28.8	29.1
Places in registered day nurseries	21.9	22.7	24.1
Child-minders			
Places with registered child-minders	101.3	109.7	121.1
Playgroups			
Places in local authority playgroups	3.0	3.2	3.0
Places in registered playgroups	385.2	398.2	403.2
(Sponsored places in non local authority day nurseries and playgroups or with registered childminders)	(8.9)	(11.2)	(12.9)

PRIVATE FOSTERING

34. There have been no further changes in the law on private fostering, which was consolidated in the Foster Children Act 1980 and came into force in April 1981. The latest statistics on the number of foster homes and privately fostered children known to local authorities during the period covered by this report appeared in Chapter 4 of the Second Report to Parliament on the operation of the Children Act 1975 (HoC Paper 20—1984).

CHILD ABUSE

35. Statutory responsibility for the care and protection of children who may be subject to abuse rests with the local authority social services departments, although health services, police, probation, education and voluntary organisations may also be involved. All areas have agreed local procedures to facilitate inter-agency communication and co-operation. Voluntary organisations play an important part in identifying and preventing abuse, the most significant being the National Society for the Prevention of Cruelty to Children (NSPCC). An important development has been the formation of a national Organisation for Parents Under Stress (OPUS) of parent support and self-help groups. The NSPCC is reorganising its field workers to set up a network of child protection teams which will work closely with local authority social services departments. To mark the NSPCC's centenary year in 1984 the DHSS made a grant of £½ million over 3 years towards the Society's headquarters costs. The DHSS has also continued to grant-aid OPUS.

36. No national statistics are available to illustrate the incidence of child abuse. Figures are available of the number of children committed to care under Section 1(2)a of the Children and Young Persons Act 1969, which is concerned with ill treatment and neglect. This does not however encompass the full range of situations where authorities work together to protect children from harm.

Children Committed to care under Section 1(2)a of the Children and Young Persons Act 1969 during the year ending 31 December—Table 2.2

(thousands)

England and Wales	1982	1983	1984
Children committed to care under section 1(2)a	2.7	2.1	1.5

Source: Home Office Statistics (based on Court Records) (Provisional)

Inquiries

37. Where a child known to the statutory services has died or has been severely injured, it is essential that the authorities concerned carry out an investigation as soon as possible to indentify any deficiencies in procedure or practice. Occasionally an inquiry by a review panel may be necessary. During the period covered by this report, reports of 2 inquiries by review panels were published; on Lucie Gates (Bexley, 1982) and Shirley Woodcock (Hammersmith and Fulham, 1984).

38. In 1982 the DHSS published Child Abuse: A Study of Inquiry Reports 1973/1981 (HMSO £2.95) This report was written by the DHSS's multi-disciplinary Child Abuse Group. It summarised and analysed 18 reports of child abuse inquiries. Amongst the most frequently occurring issues were problems over the exchange of information between professional workers, lack of regular and comprehensive reviews of the facts that were available in individual cases and misunderstanding of the roles of other professionals.

39. During the period covered by this report the DHSS began work on a consultative paper on the conduct of child abuse inquiries which was distributed for comment in July 1985.

Departmental Guidance

40. Successive Secretaries of State have issued guidance on the handling of child abuse cases to local authority social services departments, health authorities and other agencies involved in the care and protection of children. This guidance is currently being reviewed with a view to improving and consolidating it. There is a growing recognition of the problem of sexual abuse and a number of local initiatives are evolving in response to it which the review will take into account.

COMPULSORY POWERS

Supervision Orders

41. The number of children supervised by local authorities has continued to decline both in absolute terms and as a proportion of the population aged under 18. The way in which statistics on supervision orders made under the Children and Young Persons Act 1969 were collected during the period under review does not distinguish between those made in care proceedings and those made in criminal proceedings. A revised statistical return was introduced for the year 1984/85 which will provide more comprehensive information. Supervision orders made under the 1969 Act may be made with intermediate

treatment requirements; intermediate treatment is discussed more fully in paragraphs 80 to 83 below.

Children supervised by Local Authorities at 31 March—Table 2.3

(thousands)

England and Wales	1982	1983	1984
a. Under orders made under the Children and Young Persons Act 1969	16.5	15.3	14.2
b. Under the 1969 Act orders on whom an intermediate treatment requirement was made (included in a)	(3.8)	(3.8)	(3.3)
c. Under orders made in divorce proceedings	16.4	15.9	15.2
d. Under orders made in domestic proceedings	5.0	5.0	4.8
e. Under orders (unstated)	0.1	0.2	0.1
Total	38.1	36.4	34.3
per 1000 estimated population under 18	3.0	2.9	2.8

Place of Safety Orders

42. Children may in an emergency be removed from the charge and control of their parents and detained in a place of safety under a number of statutory provisions, the one most commonly used by local authorities and others concerned with the welfare and safety of children being Section 28 of the Children and Young Persons Act 1969.

Place of Safety Orders made in year to 31 March—Table 2.4

(thousands)

England and Wales	1981/82	1982/83	1983/84
On Children aged under 5	2.7	2.5	2.3
On Children aged 5 to 15	3.6	3.2	2.9
On Children aged 16 and over	0.3	0.3	0.3
Total	6.6	6.1	5.5

EMPLOYMENT OF, AND PERFORMANCES BY, CHILDREN

43. Local education authorities are responsible for administering the law on the employment of, and performances by, children. Local authorities are empowered under Section 18 of the Children and Young Persons Act 1933 to make byelaws regulating the employment of children of compulsory school age in part-time non-industrial employment not covered by other statute. Plans for national regulations, which the Secretaries of State are empowered to make under the Employment of Children Act 1973, have been postponed because of the resource implications. However most local authorities have introduced new byelaws which reflect the provisions proposed for the national regulations.

RESEARCH INTO SERVICES FOR CHILDREN IN THE COMMUNITY

44. The DHSS has continued to fund research about services for children in the community. A report has been completed on the changing resources

and practices in local authority day nurseries, carried out by Bristol University. The results of an examination of the quality of childminding in one area are expected shortly and a large programme of research on day care for the under-threes continues at the Thomas Coram Research Unit. A new study of support and training for childminders has been commissioned from the National Children's Bureau and the National Institute for Social Work has been asked to investigate the various ways of working with families and children at risk. A contract has been placed with Glasgow University for a review of the practice lessons to be learned from professional interventions in families where children have been abused.

45. Local authorities, the Economic and Social Research Council and charitable organisations also sponsor much relevant research in this field. Research projects funded by the DHSS are summarised in the DHSS Handbook of Research and Development which is published annually (and available from PO Box 21, Stanmore, Middlesex HA7 1AY).

CHAPTER 3

SERVICES FOR CHILDREN IN CARE

GENERAL

46. Children in care are mainly received into care under Section 2 of the Child Care Act 1980 or committed to care by a care order made under Section 1 of the Children and Young Persons Act 1969. The 1980 Act imposes a duty on local authorities to receive into care orphans, deserted children, children whose parents cannot care for them and other groups, provided that it is in the children's interests. The 1969 Act empowers courts to make orders committing children to the care of local authorities for specified reasons and where children are thought to be in need of care or control which they are unlikely to receive unless the order is made. Care orders can also be made under Section 7 of the 1969 Act in respect of children found guilty of an offence punishable by imprisonment in the case of an adult. A relatively small but increasing proportion of children who are in care come into care as a result of proceedings under the Matrimonial Causes Act 1973, the Domestic Proceedings and Magistates' Courts Act 1978, the Family Law Reform Act 1969, the Guardianship Act 1973 or the Children Act 1975.

47. The following tables show for the period covered by the report: Table 3.1 the reasons for children being in care; Table 3.2 the circumstances in which children were admitted into care; Table 3.3 the circumstances in which children left care; and Table 3.4 the duration of their stay in care.

Children in Care at 31 March—Table 3.1

(thousands)

England and Wales	1982	1983	1984
Children in care: total	93.2	86.6	78.9
: Per 1000 estimated population under 18	(7.4)	(7.0)	(6.9)
Reasons for being in care:			
a. Section 2 of the Child Care Act 1980	40.0	36.6	33.7
(following a resolution under Section 3 of the Child Care Act 1980; included in (a))	(17.5)	(15.9)	(14.2)
b. Committed into care under an interim care order, remanded to care or detained in care after arrest	2.0	1.8	1.9
c. Care order made under the Children and Young Persons Act 1969, other than (b)	44.4	41.0	35.5
d. Other court orders	6.9	7.0	7.8

Circumstances in which children were admitted to care during the year to 31 March—Table 3.2
(thousands)

England and Wales	1981/82	1982/83	1983/84
Children admitted to care; total	37.9	34.2	30.3
Reasons for admission			
a. Section 2 of the Child Care Act 1980	24.1	22.2	20.2
b. Committed into care under an interim care order, remanded to care, or detained in care after arrest	5.2	4.7	4.5
c. Care orders made under the Children and Young Persons Act 1969 other than (b)	7.7	6.5	4.8
d. Other court orders	0.9	0.8	0.8

Circumstances in which children left care during the year to 31 March—Table 3.3
(thousands)

England and Wales	1981/82	1982/83	1983/84
Children who left care: total	39.4	38.2	36.0
Number who left care because;			
a. Became self supporting, or care taken over by parent, guardian, relative or friend	18.9	17.7	16.0
b. Discharge of care order	4.3	4.5	4.4
c. Attained maximum age for being in care (18 or 19 as appropriate)	8.8	8.7	8.8
d. Adopted	1.9	2.2	2.0
e. Remand or interim care order ceased	4.2	3.9	3.4
f. Other circumstances	1.2	1.3	1.5

Children in care at 31 March-Duration of most recent care episode (1)—Table 3.4
(thousands)

England and Wales	1982	1983	1984
a. Under 8 weeks	5.1	4.4	4.3
b. 8 weeks but under 6 months	6.7	5.9	5.0
c. 6 months but under 1 year	8.5	7.8	6.5
d. 1 year but under 3 years	27.6	24.8	21.9
e. 3 years but under 5 years	15.4	14.8	13.4
f. 5 years and over	29.9	28.9	27.8
Total	93.2	86.6	78.9

NOTES:

1. A care episode is the period in which a child is continuously in care of a local authority without a change in legal status.

2. The number of children committed to care under the Children and Young Persons Act 1969 is understated. This is probably because records do not include some instances where interim care orders or remands to care have been followed by full care orders (see Table 3.1 and 3.2).

3. Figures may not add to totals in some of the other tables because of rounding.

4. All 1984 figures are provisional.

48. Local authorities have a general duty under Section 18 of the Child Care Act 1980 to make appropriate arrangements for all children in their

care, and to give first consideration to the need to safeguard and promote the welfare of the child throughout his childhood, ascertaining as far as practicable the wishes and feelings of the child and giving due consideration to them having regard to his age and understanding. Section 21 of that Act gives local authorities considerable discretion as to the placement of children in care and they may be accommodated in a private household by being boarded out with foster parents, or allowed to be under the charge and control of a parent, guardian, relative or friend. Children for whom these arrangements are not considered suitable or for whom foster parents are not available are in most cases placed in community homes, although a number are placed in homes or hostels run by voluntary organisations, in private children's homes which are not part of the community home system, or in residential schools, both maintained and independent. With effect from 15 August 1983 section 21(1) of the 1980 Act was amended by the Health and Social Services and Social Security Adjudications Act 1983. This added a requirement that local authorities shall as far as practicable and subject to the provisions of section 18 of the Act, accommodate children in their care near the child's home. During the period of this report there has been a continued increase in the proportion of children boarded out with foster parents and a decline in the number of children accommodated in community homes generally, and in particular those with education on the premises, reflecting the concern of local authorities to place as many children as possible within the community. These trends are reflected in the following table.

Children in care at 31 March—Manner of Accommodation—Table 3.5

(thousands)

England and Wales	1982	1983	1984
Children in Care: total	93.2	86.6	78.9
a. Boarded out	38.7	38.6	37.9
b. In community homes			
i. with observation and assessment	4.6	3.8	3.3
ii with education on the premises	4.2	3.5	2.8
iii. others	16.2	13.9	11.2
c. Voluntary homes and hostels	2.7	2.1	1.8
d. Under charge of parent, guardian, relative or friend	17.2	15.9	13.8
e. Other accommodation	9.6	9.0	8.1

BOARDING OUT

49. Table 3.5 shows that the proportion of children in care who are boarded out (the technical term for fostered) rose steadily throughout the period covered by this report, which indicated the extent to which local authorities are increasingly taking the view that fostering is, for most children, the preferred substitute for the care of the natural family. Special fostering schemes also continued to expand and develop, enabling children with special needs to benefit from care within a family. Under these schemes, foster parents are given special training and support and receive enhanced payments. Annual surveys of rates of boarding out allowances paid to foster parents by local authorities and voluntary organisations throughout the country are published by the National Foster Care Association. The surveys included payments under special schemes. The Association also recom-

mended minimum scales of allowances based on the findings of the Department of Employment Family Expenditure Survey.

50. A comprehensive set of regulations (the Boarding out of Children Regulations 1955) governs the arrangements which may be made by local authorities or voluntary organisations for the boarding-out of children in their care. They set minimum standards of practice which must be adhered to. For example, before approval of a person to act as a foster parent can be given the prospective foster home must have been visited by a representative of the agency, who must report on the suitability of the prospective foster parents having regard to a range of factors. A child can only be boarded-out if the available history of the child and the relevant reports indicate that boarding-out in that household would be in the child's best interests. The regulations also set minimum standards for continued supervision and review of the fostering placement after it has been approved. The Departments are at present reviewing the existing regulations in consultation with relevant interested outside bodies to see what changes are needed in the light of recent developments in practice. In addition the Departments expect to issue supplementary guidance on good practice in foster care.

RESIDENTIAL PROVISION FOR CHILDREN IN CARE

Community Homes

51. As noted in table 3.5 the number of children accommodated in community homes fell generally, and particularly so in community homes with education on the premises (CHEs). Coupled with a trend towards shorter stays this brought about a surplus of places against estimated need and a consequent increase in cost per place. Another factor which led to a decline in use of CHEs was the development by many local authorities of more localised residential provision for children catering for a wider range of children's needs. During the period of this report 12 assisted and controlled CHEs were closed and this trend is continuing. A number of community homes formerly used as observation and assessment centres (O & A Centres) changed in use so as to provide more local residential care and the relatively constant occupancy rates of O & A Centres is thought to reflect this shift.

52. With the reduction in the number of children placed in residential care a number of homes provided by voluntary organisations—both community homes and registered voluntary homes—were under occupied and some had to close. To help voluntary organisations over the difficulties which this shift in emphasis away from residential care has produced, the DHSS helped Child Care to mount a national conference in 1982 to seek closer co-operation between local authorities and voluntary organisations in the provision of children's services generally. The skills and experiences of voluntary child care organisations although previously mainly used in residential care could, it was believed, be used in other ways.

53. This conference "Partnership in Child Care" led to Child Care, with Departmental help, setting up regional seminars to consider the development of local co-operation between local authorities and voluntary organisations. Regional seminars were held in Newcastle-upon-Tyne, Leeds, St Helens,

Woking, Chelmsford, Birmingham, Taunton and London. These have helped to make local authorities more aware of what services voluntary child care organisations can offer and increased mutual co-operation and understanding has been reported.

Residential Placements Outside the Community Homes System

54. Under Section 21 of the Child Care Act 1980, local authorities may discharge their duty to provide accommodation and maintenance of children in their care by boarding them out, placing them in community homes or in voluntary homes or by making other arrangements which could include placements in privately-run children's homes. During the period April 1981 to March 1984 the number of voluntary homes and hostels registered under the Child Care Act 1980 fell from 189 to 140 and the number of children accommodated in them from 2,424 to 1,457. No statistics are currently available centrally on the use of privately run children's homes. Although the number of voluntary children's homes is declining there is now a tendency for them to provide more specialised care for children who have particular needs because of severe emotional or behavioural problems, or for those who, having left formal care, need support and encouragement towards independent living.

Review of Regulations for Children's Homes

55. The Regulations governing the conduct of community homes and voluntary homes, which have been in existence for a number of years, are currently being re-examined with a view to revision. There will also be new Regulations for the conduct of those homes registered under the Children's Homes Act 1982 when it is implemented. It is hoped that these will be made in 1986.

Secure Accommodation

56. New legislation was introduced during the period of this report governing the restriction of liberty of children in care. The Criminal Justice Act 1982 added a new section 21A to the Child Care Act 1980 which introduced specific criteria that must be met before a child may be placed or kept in secure accommodation. It empowered the Secretaries of State to make regulations (the Secure Accommodation Regulations 1983) specifying exceptional cases of remanded children where those criteria are not to apply, the maximum period that a child's liberty may be restricted without the authority of a juvenile court, and the maximum period or further periods a juvenile court may authorise restriction of liberty. The section also provided for the juvenile court to make an interim order on any adjournment of a hearing, for an appeal to be made to a Crown Court against the decision of the juvenile court, and required that generally the child be legally represented in any application to the court. These new provisions and the accompanying regulations came into force on 24 May 1983.

57. These new provisions apply to children received into care under Section 2 of the 1980 Act, subject to care orders, or remanded to care under Section 23(1) of the 1969 Act. The Health and Social Services and Social Security Adjudications Act 1983 extended these safeguards to other categories of children who may be accommodated in community homes. A new Section

21A of the 1980 Act and the associated Secure Accommodation (No. 2) Regulations 1983 were brought into force on 1 January 1984.

58. Placement of children in secure accommodation is not a punishment, and its use is not confined to offenders. Secure accommodation is an environment for protection or treatment where children, whose physical, mental or moral welfare would otherwise be at risk or who would be likely to injure themselves or other persons, may be cared for in the knowledge that the effects of such behaviour will be contained. In addition, children sentenced to detention under Section 53 of the Children and Young Persons Act 1933 may be placed in secure accommodation by direction of the Home Secretary (see paragraph 86 below). A number of local authorities have sought ways, during the period of this report, to develop alternatives to secure accommodation for the care and treatment of certain groups of difficult and disturbed young people. For some young people, however, placement in security is the only alternative and the Government's policy has been to work with local authorities to ensure that adequate facilities exist for this small group of children, and with the specific objective of enabling children on remand for whom placement in security is indicated to be accommodated in community homes rather than prison department establishments (see paragraph 85 below).

59. Within the community homes system the liberty of children may be restricted only in accommodation approved by the Secretary of State for such use. Secure accommodation may be either for emergency use or short term treatment, (normally in observation and assessment centres), or for longer term treatment, (normally in community homes with education). There were also a number of secure single separation rooms, in otherwise open community homes or forming part of approved secure accommodation, where children could be placed for a few hours during an outburst of violent or disruptive behaviour. The Departments have over the years encouraged the development of more acceptable ways of containing such behaviour and approval of such rooms in open community homes was withdrawn from 31 December 1983. The number of separation rooms forming part of approved secure accommodation in England has also been substantially reduced and with effect from 31 March 1984 new strict conditions governing the use of those remaining were imposed. The use made of single separation rooms is being closely monitored by the DHSS. There are no single separation rooms in Wales.

Secure Accommodation in Community Homes, approved for use at 31 December — Table 3.6

England and Wales	1982	1983	1984
Places in secure units in			
— O and A Centres	231	213	199
— CHEs	200	158	171
Secure Separation Rooms	54	22	12
Total	485	393	382

60. Capital grants may be made to local authorities for the provision of secure accommodation under Section 81 of the Child Care Act 1980. This

power was introduced in 1975, and work was started on a number of secure units during the years that followed. In more recent years greater emphasis has been placed on the replacement of out of date stock or on the refurbishment of existing facilities to enhance the quality of life of the children accommodated. A number of secure units provided by way of grant aid have been taken out of use or not brought into operation and in such cases the Departments have initiated action to reclaim the grant under the provisions of section 81(2) of the 1980 Act.

Capital grant payments to local authorities for the provision of secure accommodation in community homes by financial year at out-turn prices (1)—Table 3.7

£000

	England	Wales
1982/83	525	—
1983/84	316	—
1984/85	572	—

NOTE:

1. Local authorities are reimbursed in respect of justifiable expenditure, so grant payments lag behind the accommodation becoming available.

61. A new statistical return was introduced in 1984 designed to provide comprehensive information about the use made of secure accommodation. The first such return covered children so accommodated on 31 March 1984. Subsequent returns will provide information about all children placed in secure accommodation during the period 1 April to 31 March in each year. On 31 March 1984 there were 364 approved secure places in community homes of which 241 were occupied (196 boys and 45 girls). The majority of the children (170) had been in secure accommodation for less than three months; 27 for between three and six months; 28 for between six and 12 months, and 16 in excess of one year. A substantial proportion of those spending the longer periods in security were young people detained under section 53 of the 1933 Act. The data for 31 March 1984 suggests that, when compared with a survey on the use made of secure accommodation in 1980 (see paragraph 52 of the Report for the period 1979/81—HoC 79 1982), there has been a marked reduction in the number of children spending longer periods in security since the introduction of new legislation governing such placements.

Youth Treatment Centres

62. Two Youth Treatment Centres (YTCs) are provided under Section 80 of the Child Care Act 1980. They provide care and long-term treatment for boys and girls between the ages of 12 and 19 who are in the care of local authorities and are so severely disturbed and disruptive that they are in need of facilities and services which are not readily available in community homes. The centres also accept young people who have been sentenced to determinate or indeterminate periods of detention under Section 53 of the Children and Young Persons Act 1933 for the commission of grave crimes. For each young person in a YTC the care authority concerned is asked to meet most of the cost of maintenance. The fee charged to local authorities is reviewed annually. In 1984/85 the fee charged was £885 per week per child (the actual weekly

cost per child was £1,275). Maintenance costs in respect of children sentenced under Section 53 are met from central funds.

63. The St Charles YTC at Brentwood, Essex, opened in July 1971 and provides 30 places in three house units. During 1984 the centre's average occupancy level was 24. Within the centre's overall psycho-therapeutic approach, emphasis is placed on the development of family therapy. The second centre, Glenthorne at Birmingham, open in February 1978 and provides 40 places in four house units.In 1984 the average occupancy level was 35. Glenthorne's treatment approach is based upon behavioural methods with the aim of teaching the social controls and self-help skills which will enable the young people to find an acceptable way of life within the community.

CHILDREN WHO ARE DIFFICULT TO PLACE

64. There is a very small group of disturbed children for whom it sometimes proves difficult to find an appropriate residential placement. These children generally have severe personality and behavioural problems and are in the 15–18 age group. Because of the complexity of their problems, despite the small numbers involved, arranging suitable care and treatment creates for the authorities concerned considerable difficulties and can give rise to uncertainty about respective responsibilities. The Departments have encouraged effective joint planning and co-operation at local level together with the flexible use of resources but, because of continuing difficulties, the National Association of Health Authorities, the Association of County Councils and the Association of Metropolitan Authorities asked that the issues be reconsidered. In consequence the Health Advisory Service and Social Services Inspectorate were asked to review psychiatric services for adolescents. The Report should be available by the end of 1985 and in the light of its findings the need for further action will be considered.

PARENTAL RIGHTS RESOLUTIONS

65. Local authorities are given powers, under what is now Section 3 of the Child Care Act 1980, to assume parental rights and duties in respect of children who have been received into their care under Section 2 of that Act ("voluntary care"). Specific statutory grounds have to be met before a resolution can be passed. If a parent objects to the resolution it lapses unless the local authority brings the matter before a juvenile court for decision.

66. Recent research (see paragraphs 74–76) found that fewer than 10% of parental rights resolutions in the study were challenged by a parent in the juvenile court and that parents made little use of their right of appeal to the High Court. Since the publication of the research an additional safeguard for parents has been introduced which has been effective from August 1983. This provides that parents must now always be informed in writing of resolutions and of their right to object.

67. To encourage the development of good practice in the operation of the procedures, the Departments issued circulars of guidance[4] in January 1984

[4] DHSS Circular LAC84/5 and Welsh Office Circular 7/84.

after a period of wide consultation. The guidance reflects the findings and recommendations of the research. It emphasises the importance of effective communications with parents and of keeping them informed of and involved in the plans for their child. Examples of explanatory leaflets are attached to the circular which may be used to help explain the legal rights and responsibilities of a parent who has a child in care, as well as the duties and powers of the local authority. Local authorities are asked to explain to parents their legal rights and to direct them to any other local sources of advice.

68. The Social Services Committee, in its enquiry, did not receive any serious evidence to suggest that local authorities have abused their powers under Section 3 of the 1980 Act. The Committee reported that the powers "would by and large seem to have been used just as Parliament intended, to make possible long-term planning for children for whom there was no realistic prospect of rehabilitation with their families, without arbitrary and intermittent disruption of their lives by natural parents who for long periods showed no interest in their child and were plainly incapable or unwilling to care for them". Notwithstanding this, the Committee doubted whether it was right that such a major decision should be taken by administrative action rather than by a court and that an onus to object should be placed on the parent. The Committee recognised that there would be cost implications if the process were to be transferred to the courts, including for example an increased burden for the Legal Aid Fund. However, subject to detailed costing of the proposal, it recommended such a transfer of responsibility.

69. The Government, in its response, proposed that the working party set up to review child care law (see paragraph 15 above) should consider the formulation of provisions involving the transfer of decisions on parental rights to the courts. At the same time there will be an examination of the likely costs of such a change. There will be full consultation on any proposals before the Government reaches a decision.

ACCESS TO CHILDREN IN CARE

70. The importance of a positive approach to maintaining contact between children in care and their families has been increasingly recognised in recent years. Groups representing the families of children in care objected to local authorities having the power, as part of their responsibility for the welfare of children in care, to restrict or terminate access. They urged legislation to give families the right to seek access orders in the courts. At the same time, research has suggested that contact between children in care and their families frequently withers away even where local authorities place no restrictions on access: two fifths of the children in the study who remained in care for three years or more had lost contact with their parents after two years.

71. New provisions on access (Part IA of the Child Care Act 1980), covering most children in care, came into force in January 1984. These require local authorities to issue a notice to parents before terminating or refusing all further access to a child in care; and give parents a right to apply to a juvenile court for an access order. The court may attach conditions to the order. Local authorities or parents can apply for variation or discharge of an access order

and there is a right of appeal to the High Court. These new rights are important for parents because a decision to terminate access can lead to the permanent separation of the child from his own family. Where termination of access is followed by an application to the courts to adopt a child, the new legislation gives parents an opportunity to challenge the access decision at an early stage, before their relationship with the child is weakened and their position in adoption proceedings possibly undermined.

72. The legislation also provides for the Secretaries of State to issue a Code of Practice[5] on access to children in care. This was laid before Parliament in December 1983. The purpose of the Code is to set out the basic principles on which local authorities and other child care agencies should operate in promoting and sustaining links between children in care and their families; and in handling decisions to restrict or terminate parental access where it is necessary to do so in the child's interest. The Code stresses the importance of good social work practice, parental involvement in planning for the child and effective communication between local authority, parents and all others concerned with the child's care and welfare. Local authorities are asked to ensure that they have clear procedures for parents and other relatives to pursue complaints about access where, for example, it is restricted or made conditional.

73. The Departments are monitoring the impact of the new legislation and the Code of Practice. The DHSS's Social Services Inspectorate is examining, as part of its survey work, the operation of the Code by local authorities. The Dartington Social Research Unit, whose report on its study of links between children in care and their families is referred to in paragraph 74 below, is preparing proposals for further work on the operation of the Code and the access legislation.

RESEARCH ON CHILDREN IN THE CARE OF LOCAL AUTHORITIES

74. A DHSS financed programme of research about social work decisions in child care has recently been completed. It consists of individual studies on the admission of children to care (Exeter University); links between parents and children in care (Dartington Social Research Unit); the length of time in care (National Childrens Bureau); and long term fostering (British Agencies for Adoption and Fostering—BAAF). Lessons from these and other relevant studies are being taken into account in central policy formulation and as they have implications for social work practice, training materials are to be commissioned. In addition professional staff from the Department's Social Services Inspectorate will be initiating discussions of the research findings with practitioners from local social services departments who may then wish to examine and improve certain aspects of practice addressed by the research.

75. Research projects on certain aspects of child care law, including those mentioned above, have been used by the Inter-departmental child care law working party (see paragraph 15 above). Studies of parental rights (BAAF); solicitors and social workers in child care cases (Tavistock Institute); restric-

[5] Code of Practice on Access to Children in Care, HMSO, 1983.

tions on the removal of children from care (Keele University) and small scale work on place of safety orders, interim care orders, and the discharge of care orders (Bristol University) have all made an informative contribution. Bristol University is carrying out a study for the Department on the representation of parents and children in family proceedings.

76. Other aspects of child care policy that DHSS research has addressed include a study of reviews carried out by Loughborough University; Dartington Social Research Unit has been commissioned to monitor access by parents to children in care; and BAAF is undertaking work on the outcome of fostering placements. With regard to children who are more difficult to place two studies have been commissioned by the Department: one from Leicester University on the operation of the new court review of secure accommodation and one from Dartington following up young people with experience of a Youth Treatment Centre. The ESRC has funded a substantial programme of research on residential care, children leaving care, the costs of children in care, the movement in and out of care and fostering. Social services departments continue to carry out their own programme of research on children in their care.

CHAPTER 4

PROVISION FOR JUVENILE OFFENDERS

GENERAL

77. The Criminal Justice Act 1982 made a number of changes in provision for juvenile offenders foreshadowed in the Government White Paper published in October 1980 ("Young Offenders", Cmnd 8045, HMSO). Their main effect is described in paragraph 6 of this report. Despite early concern that the new provisions, implemented on 24 May 1983, were leading to a substantial increase in the number of young offenders receiving a custodial disposal, statistics collected by the Home Office indicate this has not been the case. Compared with 1982 (the last full year before the new provisions came into force) the number of custodial sentences (ie to detention centres or youth custody) imposed on juveniles (those aged 14 to 16) fell in 1984 both in absolute terms, and as a proportion of all juveniles sentenced or cautioned.

78. The Report of the Royal Commission on Criminal Procedure (published in 1981) drew attention to disparities in cautioning rates as an illustration of inconsistencies in prosecution practices, and recommended that steps be taken to promote more consistency. A Working Group was subsequently set up under the aegis of the Crime Committee of The Central Conference of Chief Constables to "recommend a basis for more consistent and effective police cautioning practice". Their report, published as a consultative document by the Home Office in June 1984 (Cautioning by the Police) proposed that new guidelines, including specific guidelines for juveniles, be issued to the police under cover of a Home Office Circular. Following a period of consultation the new guidelines were promulgated in February 1985 (Home Office Circular 14/1985). The guidelines relating to juveniles stressed the importance of delay in the entry of a young person into the formal criminal justice system as represented by the institution of criminal proceedings, because this may help to prevent his entry into that system altogether.

79. The total number of juveniles (aged 10–16) sentenced or cautioned for indictable offences in 1984 was about 169,000; this compares with some 168,000 in 1983 and 175,000 in 1982. Details of the method of disposal are given in the following table.

Cautions and sentences on juvenile offenders (aged 10–16) for indictable offences—Table 4.1
(thousands)

England and Wales	1982		1983		1984	
	Boys	Girls	Boys	Girls	Boys	Girls
Numbers found guilty whose sentence was:						
a. Absolute or Conditional discharge ..	16.5	3.0	16.0	2.7	15.8	2.5
b. Fine	21.1	2.7	17.7	2.2	16.0	1.7
c. Supervision Order	12.3	2.0	11.1	1.6	10.8	1.3
d. Attendance Centre Order	12.5	0.4	11.8	0.5	10.8	0.4
e. Care Order	2.9	0.4	1.8	0.3	1.5	0.2
f. Detention Centre Order	5.7	—	4.8	—	4.5	—
g. Borstal Training	1.5	*	0.6	*	—	—
h. Youth Custody	—	—	1.3	0.1	2.1	0.1
i. Community Service Order	—	—	0.5	*	1.7	0.1
j. Other sentences	0.4	0.1	0.5	0.2	0.5	0.1
Total sentenced	72.8	8.7	66.0	7.4	63.7	6.4
Numbers cautioned for an indictable offence ..	67.0	26.0	69.5	25.1	75.3	23.7
Total cautioned and sentenced	139.8	34.7	135.5	32.5	139.0	30.1

Note: * Number less than 50.
Source: Criminal statistics: England and Wales—1982, 1983, 1984.

FURTHER DEVELOPMENT OF INTERMEDIATE TREATMENT (IT)

80. Local authorities have been showing an increasing commitment to the development of intermediate treatment facilities. About £8.7 million was spent in 1981/82, increasing to around £14.0 million in 1983/84. Substantial Government support has also been given to stimulate IT development through direct grants under section 64 of the Health Services and Public Health Act 1968 and through the Intermediate Treatment Fund (administered by the Rayner Foundation). In 1984/85 these amounted to some £1,141,000 in direct grants and £453,000 in grants to the IT Fund.

81. The Criminal Justice Act 1982 had as one of its aims the reduction of custody for juvenile offenders. Custody was to be the last resort where other measures were clearly inappropriate. To this end the Act stengthened the supervision order when used in criminal cases so as to allow the courts to specify activities that young offenders would be required to undertake under the order. These provisions came into force on 24 May 1983.

82. At that time relatively few IT facilities existed which were able to provide programmes of activities which the courts could use with their new supervision order powers. Because of this the Secretary of State in January 1983 announced substantial Government help to enable new facilities to be set up quickly. These facilities were to provide intensive programmes of IT which courts could use as alternatives to custody or residential care for young offenders. Details were set out in Circulars LAC(83)3 and Welsh Office Circular 48/83.

83. £15 million of new money was made available over three years from 1 April 1983. Over that period the aim was to create new intensive IT facilities capable of dealing with 4,500 young offenders a year at a rate of 1,500 each year. Grants of up to £2,000 pa for each offender to be handled for two years were to be made to voluntary bodies specially designated by local authorities. The voluntary bodies could be existing local voluntary organisations, offshoots of national voluntary bodies under local management, or newly established for this purpose. A secondary, but nevertheless important, aim of this scheme was to promote inter-agency co-operation at local level to tackle juvenile delinquency problems and each facility has to be under local inter-agency management. The purpose was to create at local level an inter-agency forum in which local juvenile delinquency problems could be discussed and a concerted and comprehensive response to them could be advocated. In addition to managing the facilities the committees would be able to consider such related matters as use by the police of their cautioning powers, preventive measures and various follow-up programmes for young offenders after their statutory attendance on IT programmes. A variety of community agencies—statutory and voluntary—and individual members of the local community all have parts to play in this respect. Furthermore by including in such committees juvenile court magistrates or justices clerks it was hoped that courts would gain confidence in facilities set up and this could be maintained by participation in management. In this way courts would be encouraged to make full use of the facilities as alternatives to custody or residential care. By the end of 1983 applications for 40 facilities which could handle 1,396 young offenders in a year had been approved under this scheme. By the end of 1984 a total of 58 facilities had been approved, capable of dealing with 2,935 young offenders in a year. A similar initiative was launched in Wales in late 1983/84 with £644,000 being made available over three years. By the end of 1984 one facility had been approved, capable of dealing with 60 young offenders in a year.

Funding of IT Provision at Outturn Prices—Table 4.2

£000

England and Wales	1981/82	1982/83	1983/84	1984/85
Expenditure by local authorities	8,679	11,265	13,974	*
Grants under Section 64	510	784	1,106	1,141
IT Fund—Central Government Contribution	307	316	375	453
—Funds from Other Sources	40	68	13	55

Note: *information not yet available.

INTER-AGENCY CO-OPERATION

84. Throughout the period under review there was much emphasis on inter-agency co-operation in tackling local juvenile delinquency problems. Several of the local experimental IT projects given grant-aid by the DHSS had this as a major feature. Experience from these projects led to this aspect being emphasised in the design of the new IT initiative. A project to promote an inter-agency approach to local juvenile delinquency was set up in January 1982 in the shape of the Juvenile Crime Unit established by the National Association for Care and Resettlement of Offenders (NACRO). NACRO, with direct grant from the DHSS, established in 10 local authority areas

juvenile crime consultative committees comprising representatives of community agencies. These committees addressed themselves to various aspects of local juvenile delinquency with the aims of making recommendations for consideration and implementation by those concerned locally. The concept of inter-agency co-operation was further developed in Wales at a seminar organised by the Welsh Office in 1984 for the police, probation and social services and education authorities.

REMAND OF JUVENILES CHARGED WITH CRIMINAL OFFENCES

85. Section 23 of the Children and Young Persons Act 1969 provides for the remand to local authority care of juveniles charged with criminal offences, except where a certificate of unruly character is made when a juvenile may be remanded to a prison department establishment. Government policy is to phase out the remanding of juveniles to prison department establishments as resources permit satisfactory arrangements to be made for their remand to care. Such remanding of all juvenile girls and all juvenile boys under the age of 15 has ended, leaving only boys aged 15 and 16 liable for remand to a prison department establishment. The Home Secretary announced on 30 August 1984 that he had decided to take a further substantial step towards the end of some custodial remands. He proposed to introduce an Order which would define considerably more restrictively than the existing Certificates of Unruly Character (Conditions) Order 1977 the circumstances in which a 15 or 16 year old may be remanded in prison. In particular he proposed that the power should be confined to cases where the boy has been charged with murder, attempted murder, rape or other equally serious offences. Discussions on the detail of the changes to be introduced were still continuing at the end of the period covered by this report.

Juveniles remanded to prison department establishments—Table 4.3

England and Wales	1982	1983	1984
Number of Unruliness Certificates made (1)	2,270	1,831	1,678
Average daily population of untried juveniles accommodated in prison department establishments (2)	86	74	85

NOTES: 1. An unruliness certificate is normaly for seven days. Several unruliness certificates may thus be made on one juvenile during the course of a single remand.
2. Statistics are collected on the last day of each month. The figures in this table are the average of these.

SECTION 53 OF THE CHILDREN AND YOUNG PERSONS ACT 1933

86. Children who commit grave crimes may be sentenced under Section 53 of the Children and Young Persons Act 1933 to determinate or indeterminate periods of detention. Such youngsters are ultimately the responsibility of the Home Secretary. Cases of youngsters aged between 10 and 17 for whom detention in a prison department establishment is not considered appropriate are referred by the Home Office to DHSS and the Welsh Office to arrange, if possible, for their accommodation in a community home or Youth Treatment Centre. The number of children sentenced under Section 53 and the number who have been placed in child care establishments fell in 1983 after reaching a peak in the previous year but the number so sentenced rose sharply again in 1984.

Children sentenced to be detained under Section 53—Table 4.4

England and Wales	1982	1983	1984
Total Section 53 sentences	111	89	110
Number placed in child care establishments	68	53	45
Number detained in child care establishments at 31 December	92	86	73

RESEARCH INTO JUVENILE OFFENDING

87. Professor Michael Rutter of the Institute of Psychiatry was commissioned jointly by DHSS and the Home Office in 1979 to undertake a comprehensive review of all research literature on juvenile delinquency. He was assisted in this task by Dr Henri Giller of Keele University. Their report, published by Penguin Books (Juvenile Delinquency—Trends and Perspectives) in 1983, is seen as a major contribution to the understanding of the characteristics of young offenders and of the results of different forms of judicial and therapeutic interventions designed to prevent or control delinquent activities. During the period covered by this report a national evaluation of Intermediate Treatment has begun under the supervision of Professor Bottoms at the Cambridge Institute of Criminology. This includes a survey of all IT provision, an in-depth evaluation of several schemes and comparative costing work which Kent University are undertaking. NACRO are monitoring those IT projects set up with funds described in paragraph 83 above. The Home Office continues to carry out a programme of work on juvenile offending and one current project aims to assess the impact of the Criminal Justice Act 1982. The Economic and Social Research Council have launched an initiative on Crime and the Criminal Justice System with contributions from government departments. Several projects funded under this initiative address issues relating to juveniles.

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HOUSE OF COMMONS

TRADE AND INDUSTRY COMMITTEE

Session 1985-86

THE MOTOR COMPONENTS INDUSTRY

MINUTES OF EVIDENCE

Wednesday 27 November 1985

Department of Trade and Industry

Mr M J A Cochlin, Mr R A Brown, Mr R J Meadway and Mr A J Mantle

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MINUTES OF EVIDENCE TAKEN BEFORE THE TRADE AND INDUSTRY COMMITTEE

WEDNESDAY 27 NOVEMBER 1985

Members present:

Mr Kenneth Warren, in the Chair

Mr Doug Hoyle
Mr Barry Porter
Mr Robin Maxwell-Hyslop

Memorandum submitted by the Department of Trade and Industry (M22)

THE UK MOTOR COMPONENTS INDUSTRY

Introduction

1. A satisfactory, comprehensive definition of the "motor components industry" is difficult to find. Companies overlap a number of the conventional industrial manufacturing sectors and there are extensive and interlocking systems of subcontractors and suppliers. For the purpose of this Memorandum we have adopted the following definition: "components forming part of or fitted as standard equipment to on-road vehicles powered by internal combustion engines, but excluding in-vehicle entertainment, accessories and liquids". There is however no coherent set of statistics related to such a definition. For example the Standard Industrial Classification (SIC) defines motor vehicle parts as being manufactured wholly or mainly of metal (but excluding rough or semi-finished castings or forgings). Though covering a significant area of industry this, we believe, is probably too narrow for the purposes the Committee has in mind: electrical parts for example are included in figures for the electrical and electronic engineering industries. We have therefore used such statistics as seemed to be helpful from an illustrative point of view. They derive from several sources, and are frequently on different bases. This is regrettable but unavoidable.

Structure of the Industry and of its Market

The Industry

2. There are about 250 main manufacturers in the industry and, of these, it has been estimated that 20 or so of the largest account for over three quarters of the total production. In addition, there many small companies — possibly in excess of 2,000 — which are also active suppliers and which are often located near to the main vehicle assembly plants. For many of these however the vehicle assembly market and the manufacture of components represents only part of their activities. Various estimates of employment levels have been made which, depending on definition, have ranged from around 200,000 to 500,000 with a traditional concentration in the West Midlands.

3. Of the main component manufacturers a number are, or form part of, independent UK companies whilst others represent the overseas operations of multinational corporations. In addition some of the vehicle assemblers have in-house component manufacturing operations. The extent of this varies between the companies and in some cases can be very significant. Across the board, in-house components are principally for body work, engines and transmissions. However they can also cover other component areas and therefore the business potential for outside component suppliers varies significantly from assembler to assembler.

4. The component industry not only covers a number of industrial sectors but embraces

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a wide range of technologies related for example to general engineering, to electronics, rubber, plastics, ceramics and composite materials; and demand for labour force skills consequently varies from the most basic to the newest or most advanced.

The Market

5. The market for components can be classified into two basic sectors according to the vehicle type. The first, and larger market in volume terms is in respect of components for cars and car derived vans. The second market sector is for commercial vehicles and includes non car-derived vans, trucks, articulated lorries and buses. A number of component companies, some of them significant, tend to specialise in one or other of these two market sectors but others cover both sectors with the components concerned being derived from similar or parallel technologies.

6. The market can also be categorised between components supplied as original equipment (OE) to new vehicles and those supplied to the Replacement Equipment (RE) market as replacements for non-durable parts. Many of these companies supplying such parts cover both OE and RE business but there are specialists in both fields.

Position of the Industry and Recent History

7. The fortunes of the automotive components sector have naturally tended to follow those of its prime customer, the UK vehicle assembly industry, and it has therefore needed to adjust to the significant contraction in UK vehicle production over the past decade or more (Table 5 of Appendix). For example, while the market for new cars increased from 1.19 million in 1975 to 1.75 million in 1984, car production in the UK fell from 1.27 million units to a little over 900,000 units over the same period. Production has since been relatively stable at between 900,000 and 1 million units, but it is worth noting that car output in 1984 was less than half that in 1972, the peak production year. There has been a similar though more recent decline in the commercial vehicles sector.

8. Many factors contributed to this decline. For example, opportunities for exports to Britain's traditional overseas markets were steadily reduced over a period of years by the establishment of local assembly industries, a process which was generally followed by the growth of an indigenous component supply capability. This situation was aggravated by the onset of a world recession which severely depressed demand, especially for commercial vehicles, in key markets.

9. In the UK domestic market, British manufacturers were unable to prevent a steady growth in the sale of imported vehicles from Europe and Japan to the point where, since 1979, imports have accounted for over half of new car sales. At the same time the structure of the UK industry was influenced by the policies of the multinational assemblers who reorganised their production on a Europe-wide (or, more accurately, world-wide) basis, concentrating the manufacture of vehicles and major components in fewer locations in order to achieve economies of scale. In the UK, this led to a contraction in the level of built-up vehicle exports by the multinationals and, in certain cases, resulted in a movement away from the manufacture of vehicles in favour of assembly-only, with major components being imported. An increasing proportion of their UK vehicle sales were met from Continental production and in many cases there was a reduced UK content in the vehicles produced at the British plants.

10. The contraction in UK vehicle production, and the increasing proportion of the UK car parc taken up by imports affecting sales opportunities in the replacement equipment market, created pressure for change and adjustment in the automotive components sector. The response of the industry has been:—

(*a*) to cut excess capacity and manpower and to pursue rationalisation of product lines and ranges both within companies and through a policy of mergers and takeovers;

(*b*) to adopt more flexible methods of manufacturing to allow economic production levels at lower throughputs coupled with wider changes in product technology and

a drive towards higher manufacturing efficiency. The emphasis of this, in turn, has been on improving levels of reliability and quality of output;

(*c*) to develop closer relationships and links with the key assemblers—offering a mutually beneficial partnership from the research and development phase through to manufacture;

(*d*) to widen the customer base, particularly in Europe and the United States. In some cases this has required the location of some new investment overseas to match the service and local commitment of competitors. As a result of this some of the larger UK component companies derive an increasing proportion of their automotive business in terms of turnover and profitability from overseas operations.

11. Indicators of the performance of the vehicle components sector in more recent years are as follows:—

(*a*) *Output*
Indices based on components made wholly or mainly of metal (Table 1) show that whilst between 1979 and 1982 production volumes decreased by nearly 30 per cent, the two subsequent years have seen something of a recovery. The operating performance of some of the larger companies in the industry over a similar period suggests that this pattern of overall decline with a recent upturn generally applies, although clearly not relevant to every sub-sector.

(*b*) *Profitability and Employment*
There has been a reduction in employment, variously estimated at between 30 and 40 per cent since 1979, and losses, in some cases substantial, have been suffered by many companies. However, company results declared in the last two years indicate steady recovery and a return to profitability.

(*c*) *Capital Investment and R&D*
Captial investment levels declined during the recession and data, based on the narrow definition of metal components, suggests that investment in 1983 (the latest year available) was, at £54 million, about one third of the 1980 figure (Table 2).

No figures are available, even on the limited definition of components, for research and development expenditure by the component industry. But data produced by DTI (Table 3) for industrial R&D as a whole shows that the vehicle industry in total expanded its R&D in constant prices between 1981 and 1983.

(*d*) *Trade*
The overall balance of trade in motor vehicle components remains positive, although declining. Whilst the proportion of exports going to the rest of the EC is up from around one third to nearly one half of total exports, that proportion of the industry's balance of trade has moved into deficit.

Component imports from Japan have increased significantly in the last few years reflecting both the replacement equipment needs of the growing Japanese share of the UK car parc and to an extent the developing links between Japanese and UK companies. Component exports to markets other than Western Europe, the USA and Japan have stayed relatively stable in money terms. But such exports have declined in real terms and now form a much smaller proportion of total component exports.

Outlook

12. The UK components sector will continue to operate in a very difficult environment. Although an increase in the level of UK vehicle build may be expected, in order to make progress the more significant component manufacturers will require not only a sound position in the domestic market but also adequate volumes of business abroad. Yet across Europe the vehicle assembly industry is faced with substantial under-utilisation of capacity, a situation which is unlikely materially to improve in the short-medium term. This seems likely to prompt a further degree of realignment and rationalisation among the major assemblers and increased collaboration between them on major components. This process of change will place renewed pressure on the components sector for whom price competitiveness will remain a critical factor but for whom the design, innovativeness and

quality of the product will also be key elements in determining who wins the business. Companies will need to invest sufficiently in research and development, capital equipment, products and people in order to be successful in an ever more competitive market.

13. A further significant challenge facing the components industry is in the field of new technology, particularly the use of new materials, and the opportunities this provides for innovation in research and development, design and marketing. Plastics for example have already made a significant impact in the vehicle and this seems certain to continue as they offer the advantages of reduced weight and freedom from corrosion; can be moulded into very complex single piece shapes, and presented in widely differing end forms thus reducing the need for expensive operations such as machining. Equally the properties of high performance synthetic rubbers in many wider bonnet and passenger compartment applications have taken polymer materials beyond that of mere substitution for metals. Similarly, high performance composites can exhibit high strength with low weight and they will extend the substitution for metal into areas of stressed components previously thought to be out of reach. Whilst therefore companies have to consider the recovery of earlier investment in metal based technology, the challenge of new materials is there and is being addressed.

14. Another area where new technology will continue to have a significant impact is in the increased use of electronics. This falls basically into two types—those areas where the electronic equipment functions on its own as a self-contained unit, often performing functions not previously available eg in-car diagnostic equipment; and those where electronics is able to make existing products perform more effectively eg electronic control of fuel injection systems and suspensions. The potential in both cases is considerable with the prospects of significant and increasing levels of business for the successful companies. The growing importance of electronics in the vehicle is beginning to change the complexion of the component industry in certain areas with firms entering the market which had not previously been automotive equipment suppliers.

Government Assistance to the UK Motor Components Industry

15. The components sector has been an indirect but major beneficiary of the substantial Government assistance made available in recent years to UK vehicle manufacturers, particularly aid to BL. However, the Department of Trade and Industry has devoted considerable effort and resources more directly to promote the well being of the vehicle component sector. In particular financial support for research and development has been available under the Support for Innovation Scheme (SFI) to back projects leading to new and improved products and manufacturing processes. The Department has also sponsored schemes in support of the introduction of specific technologies and their development. These schemes include the Microelectronics Applications Project (MAP) scheme in support of the wider use of microelectronics in the manufacture of goods; the CADCAM scheme which provides assistance towards the purchase and installation of CADCAM equipment to aid, for example, design and other communications within and between vehicle assemblers and component manufacturers; and support towards the introduction of flexible manufacturing systems to facilitate the operation of integrated production lines and to enable economic operation at lower volumes. The adoption of these kinds of advanced technologies is seen by industry as a key ingredient to achieve improvements in quality and reliability and to maintain international competitiveness.

16. The Department also offers financial support for investment both nationwide and in the Assisted Areas with the aim of significantly improving industrial competitiveness and encouraging the growth of employment and investment. The support is made available on a selective basis taking into account the merits of the individual project and where it can be demonstrated that support is necessary for a project to go ahead. The assistance which is available under Sections 7 and 8 of the Industrial Development Act is open to all industrial sectors and, as with research and development support, the components industry has been a significant beneficiary. The designation of the West Midlands as an Assisted Area, following the recent review of regional policy, increases the component industry's potential to benefit from such assistance.

17. The Department offers a wide range of other services and schemes to manufacturers, large and small, including help with exports, and the automotive components sector makes full use of these.

18 *November* 1985

APPENDIX

TABLE 1

VEHICLE COMPONENTS: INDEX OF PRODUCTION

1979	*1980*	*1981*	*1982*	*1983*	*1984*
100	86.4	75.8	71.8	74.7	75.5

Source: Department of Trade and Industry.

The index is based on Activity Headings 3521 and 3530. Comparable figures prior to 1979 are not available.

TABLE 2

VEHICLE COMPONENTS: GROSS CAPITAL EXPENDITURE

£m

	Current prices	*Constant (1980) prices*
1979	210	234
1980	133	133
1981	100	93
1982	63	54
1983	54	44

Source: Annual Census of Production.

The figures are based on Activity Heading 3530 but comparable data prior to 1979 is not available. The figures relate to investment in buildings, plant and machinery and vehicles.

TABLE 3

VEHICLE INDUSTRY: INDUSTRIALLY PERFORMED R & D

	1975	*1978*	*1981*	*1983*
Current Prices				
All manufactured products	1,293	2,243	3,549	3,901
Motor vehicles and parts	88	130	180	240
Constant (1975) prices				
All manufactured products	1,293	1,512	1,555	1,465
Motor vehicles and parts	88	88	80	91

Source: Department of Trade and Industry Survey.

The figures cover motor vehicles engines, parts, motor and pedal cycles and miscellaneous vehicles.

TABLE 4

TRADE IN MOTOR VEHICLE COMPONENTS

Region *UK Exports to:*	*1975*	*1976*	*1977*	*1978*	*1979*	*1980*	*1982*	*1983*	*1984*
EEC	387	587	742	797	904	927	976	1,020	1,119
Spain	9	17	22	26	25	32	63	83	134
EFTA	179	200	213	212	245	266	229	199	204
USA	121	166	164	155	183	174	111	194	260
Japan	5	5	6	6	8	7	6	7	9
Others	450	529	495	547	548	638	565	516	599
Total Exports	1,151	1,504	1,642	1,743	1,913	2,044	1,950	2,019	2,325
UK Imports from:									
EEC	279	429	548	668	884	736	1,050	1,381	1,462
Spain	8	17	28	26	20	35	62	73	99
EFTA	25	32	33	34	62	57	78	97	117
USA	47	66	62	60	72	71	82	88	101
Japan	16	20	41	42	52	36	115	136	157
Others	21	38	45	47	59	56	82	117	159
Total Imports	396	602	757	877	1,149	991	1,469	1,892	2,095
Balance	755	902	885	866	764	1,053	481	127	230

Source: Society of Motor Manufacturers and Traders.

The components covered by the Society's data are close to those embraced by the definition of components in this paper and provide a more appropriate indicator of trade levels than the figures available under the more restricted SIC definition.

No figures for 1981: strike action that year affected the availability of complete data.

TABLE 5

VEHICLE STATISTICS

	UK Vehicle production 000's		*Registrations of new vehicles in the UK 000's*		*% of new registrations taken by imports*	
	Cars	*CV's*	*Cars*	*CV's*	*Cars*	*CV's*
1975	1,268	381	1,194	225	33	11
1976	1,333	372	1,286	215	38	14
1977	1,328	386	1,324	231	45	16
1978	1,223	385	1,592	262	49	21
1979	1,070	408	1,716	306	56	23
1980	924	389	1,514	272	57	24
1981	955	230	1,485	218	56	31
1982	888	269	1,555	231	58	29
1983	1,045	245	1,792	268	57	34
1984	909	225	1,750	269	58	36

Source:
Business Monitor.
Department of Transport.
Society of Motor Manufacturers and Traders.

TABLE 6

SUMMARY OF MOTOR VEHICLES IN USE IN THE UK (THE UK CAR PARC)

000's	*Cars*	*CV's*	*Total*
1975	14,061	1,927	15,988
1976	14,373	1,912	16,285
1978	14,417	1,855	16,272
1979	14,927	1,933	16,860
1980	15,438	1,913	17,351
1981	15,633	1,883	17,516
1982	16,075	1,850	17,925
1983	16,612	1,691	18,303
1984	17,313	1,589	18,902

Source: Department of Transport.

In 1975 and 1976 sample census figures were used. No census was taken in 1977.

Examination of Witnesses

Mr M J A Cochlin, Grade 3, Head of Vehicles Division, Mr R A Brown, Grade 5, Mr R J Meadway, Grade 5, and Mr A J Mantle, Grade 5, respectively Heads of Branches 1, 2 and 3 of Vehicles Division, Department of Trade and Industry, called in and examined.

Chairman

1. Before we formally commence our proceedings this morning I would like to make the announcement that in view of the very serious tin crisis which is facing the United Kingdom at the moment we are going to carry out an inquiry into it and will commence hearings on that subject as soon as possible. We will be issuing a formal press notice in the next 24 hours. We are opening our inquiry this morning into the motor components industry, but we will then suspend that inquiry until we have completed our inquiry into the tin crisis. This morning we welcome witnesses from the Department of Trade and Industry. I start by saying this Committee is very much aware that United Kingdom motor vehicle production has declined substantially during the last decade, and the purpose of the inquiry is to establish how this has affected the motor components sector. In welcoming you, Mr Cochlin, it would be helpful if you could introduce the team accompanying you and, furthermore, indicate for how long each witness has been in his present post and his general background knowledge of the motor vehicle industry.

*(*Mr *Cochlin.)* Thank you, Chairman. I am Michael Cochlin, Head of the Vehicles Division of the Department of Trade and Industry. I have been in that post for a little over 12 months. Before that I was in another position within the Vehicles Division where I looked after relationships particularly with the multi-national companies, and before that I had a range of postings within the DTI, including the Trade side. Might I introduce John Meadway on my right whose particular responsibility is the Government's relations with BL and also general motor industry issues and international issues which affect the motor industry in this country.

*(*Mr *Meadway.)* I have been in this post for two years, and before that I spent about five years working on international trade policy, Community trade policy and GATT. That was my area of responsibility.

*(*Mr *Mantle.)* I have been looking after the components industry branch dealing with components for cars and agricultural machinery for 18 months. I am a generalist and have had other posts in the Department, and formerly I was a practising metallurgist.

*(*Mr *Brown.)* I am Michael Cochlin's successor and look after the multi-nationals located here. Before this post I was dealing with exports, and before that I was on secondment to Leyland Truck and Bus at Leyland in Lancashire. Before that I was in the Department of Transport with responsibilities for public transport and the bus industry in particular.

2. From your experience, is there a free-standing motor components industry, or is it in fact a sector of the motor industry?

*(*Mr *Cochlin.)* I find it hard to distinguish between the two. The fortunes of the components sector in the United Kingdom very much follow those of the motor industry

[Chairman *Contd.*]

as a whole. One of the effects of the decline in motor vehicle production in the United Kingdom is that the component companies, formerly excessively dependent on domestic business, were forced to look to world markets for their future and in the process developed themselves as truly independent companies, and that is a trend which one sees continuing. I am not sure if that is the point of your question.

3. I would like to know how you see the industry. Do you treat it as two separate parts: components and vehicle assembly?

*(*Mr *Cochlin.)* In some senses, yes, but one must be careful because the assemblers themselves have significant component operations of their own and a number of issues affecting them on componentry are similar to those of the independent manufacturers, but what we do try to achieve in the Department is a separate dialogue with the respective sides of the industry. We have very close relationships with the assemblers and meet regularly and talk in detail about their plans and operations. Equally, we have a regular dialogue with representatives of the components industry under the umbrella of the SMMT; we have discussions in a consultative group, perhaps quarterly, dealing with issues which affect them as an industry and as a supplying industry for the assemblers, so we have both dialogues going.

Mr Hoyle

4. To follow what you were saying, that you feel the components industry is a separate entity, how far has it gone for export business overseas? Can you spell out a little more how far they are still dependent on the indigenous motor industry?

*(*Mr *Cochlin.)* I think it is dangerous to generalise on this question because the experience differs considerably between companies, but there are major component companies perhaps half of whose business originates overseas either through direct exports or through income from overseas operations. They have found this to be an essential strategy in order to survive on a world competitive scale, so I think that in a number of the larger companies you will find a relatively high proportion of their business, and perhaps an increasing proportion, moving away from the UK in terms of customer base.

5. And factory location as well?

*(*Mr *Cochlin.)* Factory location is often the necessary entrée to a market where the customer demands ready access to his supplier.

Mr Maxwell-Hyslop

6. It was not a great success when Willmott Trading tried it?

*(*Mr *Cochlin.)* It does not always succeed.

Mr Porter

7. As a rough percentage, what proportion of the motor component industry is now operating abroad?

*(*Mr *Cochlin.)* I would say that all major companies are trading overseas, and perhaps all the top 20 would have operations overseas in significant markets, some in more countries than others depending on the pattern of their business.

8. Is it possible to find out what the percentage is?

*(*Mr *Cochlin.)* We will see what we can do at least for the significant companies.

Mr Hoyle

9. Is not one of the criticisms of the components industry from foreign manufacturers of vehicles that they cannot provide the quality because of lack of investment here? Does it not rather go against what you say, apart from factory location?

*(*Mr *Cochlin.)* I do not accept that. It may be true in some cases, but we are still a significant exporter of components. The component companies are still selling to the major world producers of vehicles, even to Japan in some cases, but certainly in the United States and Europe. There is a fierce competitive climate and yet we are succeeding, so I think that for a large part of the industry what might have been former failings in quality or price competitiveness or reliability are problems which have been addressed and in a number of cases remedied; they are winning the business, and our experience from talking to vehicle producers in this country is that there has been a very dramatic change in performance from that sector in the past five or six years. Of course, it is not a uniform story; there are weaknesses and some companies do still need to put their house in order.

[Mr Hoyle *Contd.*]

Chairman

10. As I understand it, at the moment the official definition of the motor industry is MLH 381 which refers mainly to metal components. In view of the growth of electronic, rubber, glass and plastic items used in the manufacture of motor vehicles, do you think the time has come to redefine MLH 381?

*(*Mr *Cochlin.)* It is certainly less than ideal as a definition of the components sector. It provides an indication of trends, but it is by no means comprehensive. The advice I have from the statistical services is that the prospects of an early change in that definition seem fairly remote. The statistical base in the United Kingdom is aligned to the EEC's which in turn harmonises definitions with the rest of the world. It is in an international forum where alignment and harmonisation has taken place in recent years, and it still has some way to go in trying to create some unanimity in statistics. I would sense that the chance of restructuring these statistics in the foreseeable future is not part of their thinking at the moment.

Mr Hoyle

11. What proportion of total component production do the "250 main manufacturers in the industry" account for?

*(*Mr *Cochlin.)* I cannot answer that. The figure of 250 is not one we put forward with any precision. What we are trying to do is give an order of magnitude to explain the structure of the industry. The top 20, by common consent, accounts for around three-quarters of total production, so I would guess that if you added the 250 medium companies to that you would get to about 85–90 per cent of the industry, but that is pure guesswork; we do not have the data to support it.

12. When you talk about the top 20 companies, are vehicle manufacturers included in that? Is there any double counting in the total of 250?

*(*Mr *Cochlin.)* No. The top 20 are the component operations of independent companies, not the assemblers themselves.

13. As to your estimate of employment in the United Kingdom component industry, you say the figure varies between 200,000 and 500,000, but apart from that we have the multiplier effect. There are companies which manufacture components but which are not solely component manufacturers; and you also have to go back to basic manufacturers, like steel, coal and textiles. Are those included? What would you say is the total number of people actually employed in the industry? The total must be far greater if we take people who are not directly involved; it must provide quite a sum of revenue for them?

*(*Mr *Cochlin.)* Again, we have problems with the statistical base. The only recent study which has been done of the actual benefits of the sector is that contained in the PEIDA report produced for the SMMT. That looked at various levels of employment resulting from the activities of motor assemblers; it went not only into primary suppliers but material suppliers and material sub-suppliers. Their estimate, taking it all together and making adjustments for the time span since the report was written, was about 500,000 for total motor industry-linked employment. We do not quarrel with that as an order of magnitude.

14. That is quite separate from the 177,000 directly employed by motor assemblers, making a total of about 700,000?

*(*Mr *Cochlin.)* Yes, that is right.

15. Is the regional spread of the components industry more diffuse than that in vehicle assembly, because I think that in almost everybody's constituency there must be some company manufacturing something for the motor industry? What would you say about the regional spread of the components industry as against that of the vehicle assemblers?

*(*Mr *Cochlin.)* Vehicle assembly is fairly spread in the sense you have Ford and Vauxhall in the southeast and also in the northwest; you have Nissan in the northeast, as well as BL Talbot and the specialised car companies in the Midlands. I think that in terms of componentry there has traditionally been a concentration in the West Midlands. That is still true. At the same time, there are important parts of activity in other areas: there is activity in South Wales, and the Leeds/Bradford area is another section where there are clutches of quite important companies. If you go to the smaller companies, the 2,000 in the total industry, they are quite widespread and there is no particular concentration.

Mr Porter

16. I would like to ask some questions about the impact of multi-national companies, and I am glad to have two experts

[Mr Porter *Contd.*]

here. First of all, are the multi-nationals taking a larger share of the UK components market and, if so, at what sort of rate are they taking that larger share?

*(*Mr *Cochlin.)* Looking back over the past decade, I think they have been offering less business to the components sector than they used to. This has been a function of a number of things, one of which is the movement by one or two companies away from the manufacture of cars, which in turn created a demand for local components, towards the assembly of cars based on imported components or kits. There has been a move away to continental production by one or two of the multi-nationals——

17. I think we might be at cross-purposes. I am talking about multi-national component makers?

*(*Mr *Cochlin.)* I beg your pardon. I think the answer is that it is less than it was. For example, in the case of General Motors they used to have fairly significant component manufacture on the car side which has disappeared, and in the case of Peugeot (Chrysler as it was) there was a fully manufactured vehicle in their production line some years ago, and that has disappeared. There remains a fair degree of component manufacture as regards commercial vehicles, but I do not think it has changed relatively very much in recent times. One must also look at Ford which has been investing, and continues to invest, in component manufacture to a substantial degree. I think in answer to your question the balance has probably diminished in recent years.

*(*Mr *Mantle.)* There is a reverse effect in the case of the multi-national component companies, in that some of the major UK companies are now multi-nationals in their own right. For example, Lucas through subsidiaries in Europe may supply brakes to foreign markets as a multi-national.

18. Is there a trend for UK components firms to be taken over by foreign firms and, if so, how many have been taken over in the last 10 years? What is the sort of rate?

*(*Mr *Cochlin.)* There is no distinct trend for the take over of UK firms which we have noticed in the last couple of years.

19. Would you be able to give any examples of UK component makers who have been taken over by foreign firms in the last 10 years?

*(*Mr *Cochlin.)* We would need to take a look at that; there is no conscious trend.

20. Is it significant?

*(*Mr *Cochlin.)* There is no obvious trend in that direction.

21. Have you any idea what the Government's attitude might be to a foreign bid for a front-ranking component maker?

*(*Mr *Cochlin.)* I think the Government's interest would be in seeing there was a viable, prosperous component sector; I think the question of ownership would be a secondary consideration.

Mr Hoyle

22. To follow it up, although Mr Porter was talking about multi-national component manufacturers, you appeared to be concentrating on multi-national motor manufaacturers. He was asking whether component manufacturers like Lucas were taking a greater share of the UK components market. To return to something you said earlier, you said that in certain cases they manufactured overseas. Is it not a fact that they move into low labour cost countries to get the benefits of that rather than remain here? Why should Lucas move into Europe to reach the European market? Surely, it can be done from here just as easily?

*(*Mr *Cochlin.)* I think they do both. You will find they are significant direct exporters where they can be to particular markets, but in certain cases in certain markets where you can expect a fairly significant volume of business the customer will expect you to have a local presence. The nature of that presence and the degree to which they require manufacture or assembly will depend on particular cases, but I think you do reach a certain point when you are penetrating important markets where the level of business makes it very difficult for you to avoid local production if you are to retain customer loyalty.

Mr Maxwell-Hyslop

23. Turning now to the actual market, to what extent are commercial vehicles more component intensive than the cars we have been talking about, and as well as commercial vehicles I mean car-derived-vans?

*(*Mr *Cochlin.)* I will bow to my colleagues' judgment on this. I think the number and complexity of components would be far

[Mr Maxwell-Hyslop *Contd.*]

higher for cars and, let us say, car-derived-vans; I think the car would be streets ahead in terms of variety and volume of components.

24. Obviously, there are far more cars sold, but in terms of the percentage of the complete car that is represented by bought-in components, as compared with a HGV, in terms of the proportion of the total value, you are telling us that the car has a higher bought-in component proportion than an HGV?

*(*Mr *Cochlin.)* Not necessarily bought in in the sense the components may be manufactured inhouse by the vehicle assembler. What I was suggesting was that physically the range of components and the range of business available——

25. To stop you there, we may be employing words differently. If you call every part number of a car a component we are not using words in the same way. By "components" I mean parts of the vehicle that are bought in and not manufactured by the manufacturer himself, anything from braking systems, seats, glass, instruments and batteries to alternators and clutches. I am using the term "components" to mean that which is not manufactured locally by the vehicle assembler who sends the vehicle out to the wholesaler or retailer. If you want to have an inverse definition, I am referring to the components industry as I though we had agreed its definition at the beginning of the questioning this morning.

*(*Mr *Brown.)* I think it would be useful to consider a more detailed answer to the question. Our initial reaction would be that the commercial vehicle industry tends to be less integrated at the moment than the car manufacturing industry—hence, for example, engines are increasingly bought in from Cummins and Perkins, axles are bought in from Eatons and Rockwell, so there is a tendency to buy in for some of the major components.

26. If you look at the component manufacturing industry as opposed to the vehicle assembly industry, what proportion of their turnover goes to non-passenger vehicles? I use the term "non-passenger vehicles" to include HGVs, commercial vehicles of all kinds and also car-derived-vans.

*(*Mr *Cochlin.)* If I may, we would like to think of the answer. I would hazard the guess that about one-quarter of their total business is in commercial vehicles, but I would like to think about that, if I may.

27. If we turn to agricultural tractors and construction equipment, they are items made by specialist manufacturers, and they are quite clearly different markets. What is their importance to the component manufacturers in the sense in which we have been using the term "component manufacturers" this morning? I want to make sure we all know what we are talking about. Are you including tyres in your answer or not?

*(*Mr *Cochlin.)* In a broad definition, yes.

28. Let us take agricultural tractors first and then construction industry equipment.

*(*Mr *Cochlin.)* On tractors, the answer is that for some companies tractor production is important, diesel engines were mentioned a few moments ago. As to tractor production in the United Kingdom, these are important outlets for the manufacturers of engines who in turn are also supplying the vehicle sector, and that goes for a range of other components which are common to the automotive industry—wheels, tyres, gearboxes, heat exchangers, electrics and the like. In terms of proportions, as a guess, again subject to further study, I would have thought that perhaps 10–12 per cent of a typical component manufacturer's business would be in that sector.

29. When we look at exports of vehicle components, are those primarily manufactured by the vehicle exporter? I am thinking, for instance, of the knock-down kits sent to Iran. Does the vendor of the knock-down kits invoice Iran for components not manufactured by him but which go with the kits, or are the Lucas parts sent by Lucas separately from the automotive parts?

*(*Mr *Cochlin.)* The financial transaction is between, in this case, Talbot and the Iranians. Talbot export kits which in turn have been bought from independent suppliers.

30. As though they had assembled it in the first place?

*(*Mr *Cochlin.)* Yes; it is a continuation of their business; they are simply packaging it rather differently.

31. What can you tell us about the comparative volume and also the comparative value of the original equipment market and the replacement equipment market to the components business? You

[Mr Maxwell-Hyslop *Contd.*]

may want to add to that the comparative profitability of original supplies, because I will be asking you about that as well. That was why I phrased the question in the way I did. I want to know the comparative values in terms of volume and in terms of revenue of sales of original equipment as against post-initial sales replacement?

*(*Mr *Mantle.)* I think that in terms of the question as you put it we would have to look ——

32. How would you prefer that I put it? Let us take the home market first to make it easier. What proportion of the component industry's output as you define it is original equipment, that is, by number of units as opposed to items, and would you give it in terms of value?

*(*Mr *Mantle.)* It is impossible to say, because we do not know, for example, whether a Lucas starter or alternator manufactured on a given day will go to the replacement market or will be original equipment.

33. I did not ask if you knew that, but if you want to take starters, what proportion of Lucas's output of starters goes as original equipment and what proportion goes for spares?

*(*Mr *Mantle.)* We do not know that; we could not give you the answer.

34. You would expect Lucas to know?

*(*Mr *Mantle.)* Yes, I would.

35. Is it worth asking you about comparative profitability, or is that something which has to be asked of each firm seriatim?

*(*Mr *Cochlin.)* I think traditionally the replacement market for vehicle manufacturers has been a far more profitable business than OE, but that is changing.

36. Who makes the profit—is it the retail outlet or the car manufacturer? In the days of retail price maintenance this was not a very difficult question to answer because if all parts are bought as manufacturer's part numbers by way of replacement so it is a vertically integrated sales operation obviously you have the answer, but to the extent that a component manufacturer either sells directly to the public or through retail outlets which are not owned by, or are not the agents of, the vehicle manufacturer, to say that the price the customer pays compared with the price the manufacturer pays originally is greater for spares than for original equipment is not to say that the component manufacturer receives more for the sale of spares, and it is that I want to find out in order to establish its relative importance to the component manufacturer. It is volume times unit profit, is it not? How can you help on this line of questioning?

*(*Mr *Cochlin.)* I would not like to hazard a guess at the answer without looking at it.

37. What sectors of the component manufacturers' business have little replacement market? One hears about the effect of steel radial ply tyres replacing fabric cross-ply tyres, but beyond that obvious example, what have you to tell us?

*(*Mr *Cochlin.)* In terms of the items which are the greater part of the replacement market——

38. I am talking about the trend towards producing sealed units which have to be replaced in toto, compared with the days when the defective parts of a dynamo (before the days of the alternator) would normally be repaired by a garage rather than a complete replacement unit fitted?

*(*Mr *Cochlin.)* Again, I really would like to think about your question. Clearly, cars are becoming more reliable and——

Mr Maxwell-Hyslop: We will not waste time on that.

Chairman

39. Let us move on to the operating environment. The statistics which you kindly gave us with your memorandum note the well-known decline in UK car and commercial vehicle output, but the total demand has remained about the same. What has happened is that imports have taken the place of home manufactures. Has this situation put any major component companies in jeopardy?

*(*Mr *Cochlin.)* It has made life very difficult for quite a number of them. They needed to adjust to that over a period of years, primarily by looking for volume elsewhere in Europe and further afield. Undoubtedly, volume has been critical to competitiveness and the loss of a sizeable home market has done a great deal of damage which has been fatal to some, whereas others have made the adjustment.

Mr Hoyle

40. Can you quantify that in terms of employment in the industry? What sort of reduction has it brought about?

[Mr Hoyle *Contd.*]

*(*Mr *Cochlin.)* In the past five or six years the total loss of employment in the components industry, as a guesstimate, is about 250,000–300,000 people.

41. Would you say this has been brought about mainly because of the decline in the UK car and commercial vehicle output or because multi-nationals are bringing in parts from overseas and assembling them here?

*(*Mr *Cochlin.)* I think it is a combination of the level of imports by the multi-nationals—the so-called tied imports—and the level of direct imports from Europe; and it is also a reflection of the world recession which hammered export prospects for the commercial vehicle sector and the tractor sector. I think it was the changing nature of the UK market and export prospects which combined to cause that loss of employment.

*(*Mr *Mantle.)* One should also add there has been a general improvement in productivity in the manufacturing industry over the last few years and as a result of the processes being performed more efficiently there has been a reduction in employment in the components industry as in any other.

Chairman

42. If I may refer you to your Table 4, I think there is one small correction to be made in the top line; the penultimate column ought to be "1983", not "1973"?

*(*Mr *Cochlin.)* Yes.

43. I take it these figures are in pounds sterling at current values?

*(*Mr *Mantle.)* Yes.

44. Could you let us have in due course the bottom line of imports and exports at constant pounds, whichever year you wish to choose, because it is rather difficult to tell what has happened? As I read it now without that information, we seem to have lost a lot of exports. Is this true? Has our export market declined in motor vehicle components?

*(*Mr *Cochlin.)* I think it would be; at least they have not grown very significantly.

45. In terms of imports, it is quite clear that the number of motor vehicles which have been imported has grown very substantially, and presumably this has been at the expense of our home manufacturers?

*(*Mr *Cochin.)* Yes, in part at least because of the rise in the number of imported vehicles in use in the UK; it is the after market which has also taken the toll.

46. But would these be imports by people like Peugeot Talbot into this country because they want to have their own parts as opposed to sourcing locally?

*(*Mr *Cochlin.)* That is an element. Where you have the assembly of vehicles here on the basis of imported kits and components that would show up in the statistics.

Mr Maxwell-Hyslop

47. The statistics to which reference has been made by the Chairman show the alarming fact that in 1975 the ratio of British component exports by value to imports was of the order of 3: 1; 10 years later (1984) it is 1.15: 1, just looking at the figures here. Is that something you regard with equanimity or, if not, pray tell us to what do you attribute that astonishing alteration in ratio?

*(*Mr *Cochlin.)* It is partly a problem of export markets but primarily a reflection of what is happening in the domestic market. As well as increasing import penetration we have less UK content in the vehicles we produce here, and the combination of both those things means that in the after market, particularly through the franchises, there are more imported components being used than hitherto. We do not regard that trend as one we would like to see continuing, which is why we are encouraging through various ways a greater volume of domestic build and a higher level of UK content in the UK build amongst all UK producers.

Mr. Maxwell-Hyslop: But the parameter which I put to you, the ratio of export to import volume, is of considerably more interest than the figure you have chosen to give, which is the balance between the two arrived at by subtracting one from the other? I would have thought the ratio I put would be of far greater interest than this figure. Why did you not give the ratio instead of the balance?

Chairman

48. Is it because you obtained it from the SMMT in the form in which you have given it to us, or is it your own table using SMMT as the source?

*(*Mr *Cochlin.)* We have reproduced the SMMT table which in turn is based on official statistics.

Chairman: I think Mr. Maxwell-Hyslop has put a valid point; that ratio is extremely important.

Mr. Maxwell-Hyslop: It would be more helpful to give the ratio than the balance because it is the ratio which is so alarming.

Chairman

49. Do these vehicle component statistics include knock-down kits, because there has been a substantial increase in knock-down kits over the 10 years on which you are commenting here? They are not classed as components but as cars.

*(*Mr. *Cochlin.)* If the kits comprise enough components to classify them in that way, that is the case; there is I believe a 50 per cent cut-off in terms of the value of the car. I suspect the statistics are at least in part a reflection of the kit traffic.

50. What is the effect of the import of cars in kit form for UK assembly on the motor industry in this country?

*(*Mr. *Cochlin.)* I think a loss of opportunity for domestic suppliers in the sense they would need to sell to the source of those kits and therefore would need to compete with local suppliers in Germany, Belgium or wherever; it would be far more difficult to break into that market than supply to a UK producer.

*(*Mr. *Brown.)* Equally, the number of kits assembled in the UK is relatively small at the moment. Perhaps another characteristic is that we have lost the chance to export kits as markets in the Third World in particular have developed; those countries have wanted to have their own assembly operations, and Japanese and other world competition has forced us out of our traditional markets in Africa and the Far East.

51. What is the Government's policy on the future development of the car industry in this country? Are you looking for a decline in tied imports and an increase in the UK content of cars?

*(*Mr. *Cochlin.)* Yes, for both. The Government's hope is that it will benefit the manufacturers to do both those things, that the UK will be an efficient place in which to make cars, will make more cars than they are now, and that the component supply industry itself will be fully competitive with alternative sources outside the country. The discussions which are taking place with the manufacturers are encouraging them in both directions. Tied imports are, of course, a matter of some concern; they have risen fairly sharply in recent years. We believe there is now a prospect that that trend will be reversed. Certainly both Ford and particularly Vauxhall have recognised the problem and have taken——

52. Are they prepared to do anything about it?

*(*Mr. *Cochlin.)* In the case of Vauxhall they have taken initial steps which are encouraging. They have established at GM European level a high-level task force to look at the prospects of sourcing more components in the UK both for their UK production and for their German production. We have met them on a number of occasions and we are convinced they are serious. It will obviously take time for the results of the work to come through, the main opportunity being in the next generation of vehicles produced by GM in Europe. We have hopes that there will be a significant change in the pattern of their purchasing when that happens.

53. Have you laid down the law to Nissan on the subject?

*(*Mr. *Cochlin.)* I think Nissan have themselves recognised that to be acceptable in Europe as producers they would need to show they were true European manufacturers and were not assembling Japanese kits. From the outset of the discussions with the Government on their project they recognised the need to have a high level of local content in the vehicles they produced here and are themselves committed to achieving 80 per cent within 18 months of the start up of full production.

54. Is that 80 per cent of value?

*(*Mr. *Cochlin.)* Yes.

Mr. Porter

55. You sound fairly optimistic about Vauxhall and the future UK content. Surely, if my information is not incorrect, Detroit will take some persuading to do that which your persuasive tactics have not so far achieved?

*(*Mr. *Cochlin.)* They might not be persuaded if we are not producing clearly competitive products in the UK. Our expectation is that when they examine what is on offer—and they are now doing it seriously (which was not perhaps the case until recently)—they will find they will not lose commercially by sourcing locally, that we can produce goods which are price and quality competitive and are reliable and it would not be such a tough decision for them. There are entrenched interests on the continent which would suffer from any switch in sourcing, but it is straight competition between ourselves and the continent. GM have recognised that their image here is important and feel that if

[Mr. Porter *Contd.*]

they continue with very low levels of UK content in time it will impact on their sales.

56. Is it right to say there is a divergence of opinion at the moment between those people who work for and manage Vauxhall in this country and the big men in Detroit?

*(*Mr. *Cochlin.)* No, I do not think there is a divergence on this particular point. Obviously, there will be some tensions between UK and German management in the sense we are talking about the UK taking business away from the German components industry.

*(*Mr. *Brown.)* It might be helpful if we distinguish between the two ways in which the Government is trying to make some progress with GM in particular: first of all, to try to increase the local content of vehicles which are manufactured here. The decisions reached by GM will be taken on commercial grounds. Is the UK competitive with other centres of supply? The Chairman of Vauxhall has already said that it is his intention to raise the content of his UK-manufactured cars and car-derived-vans from 45 per cent to 56 per cent by the end of this year.

Chairman

57. By value?

*(*Mr. *Brown.)* Yes, by value. The second element where Detroit is directly involved concerns further investment that is required to increase the total number of cars manufactured here. Detroit may well have a different view on the additional investment they need on local content, and it is that subject which is at issue between the two of us at the moment.

Mr. Porter

58. To continue this line of questioning about the role of motor vehicle manufacturers in the components industry, how crucial is BL to the components industry? I am sure you can answer that shortly.

*(*Mr. *Cochlin.)* In quite a number of cases, crucial.

59. Although Ford is a multi-national, is it as important to the motor components industry as BL?

*(*Mr. *Cochlin.)* Again, in many cases it is as important.

Chairman

60. Can I ask if in fact the state support for BL has been the largest support given to the components industry indirectly?

*(*Mr. *Cochlin.)* Yes, by a large margin. It goes to other companies in the industry but not on that scale.

61. Have other vehicle manufacturers received similar assistance, or has it been assistance in the form of location?

*(*Mr. *Cochlin.)* They have taken advantage of general schemes under sections 7 and 8 of the Industry Act, but the orders of magnitude are quite different. We are talking of perhaps £70 million or £80 million over the past three years—something of that order—for non-BL assistance.

Mr. Porter

62. How important would you assess the Iranian contract with Peugeot Talbot to be to the components industry in this country?

*(*Mr. *Cochlin.)* I think it is quite important; on a good day it is worth £80 million or £90 million, and certain component companies obviously derive substantial benefit from that. At the same time, I would not overestimate it as a proportion of the business of any one company.

Mr. Maxwell-Hyslop

63. Did I understand you to say that it was worth £90 million or £80 million a day?

*(*Mr. *Cochlin.)* I am sorry; it is worth £80 million-£90 million a year. I was referring to the uncertainties and the difficulties being experienced with the Iranians over the past two or three years; the situation has fluctuated dramatically over that period.

64. And the uncertainty of getting paid?

*(*Mr. *Cochlin.)* Yes.

Mr. Porter

65. How important would you assess the United States to be to the industry?

*(*Mr. *Cochlin.)* I think in the long term it is very important.

66. Does the increased foreign penetration of the UK car "parc" inevitably result in a fall in the components replacement business?

*(*Mr. *Cochlin.)* It has tended to have that effect. The access to the franchise dealerships

[Mr. Porter *Contd.*]

has been eased a little by Monopolies Commission recommendations, but it is still true that the more imports are represented in the car "parcs" the more imports of components are likely to follow.

*(*Mr. *Mantle.)* Increasingly, component companies are getting replacement parts for foreign cars on to the British market virtually as quickly as the foreign producer himself.

Mr. Maxwell-Hyslop

67. Is this trend being in any way impeded by changes in copyright or patent law, that is, the ability of Lucas to offer a part that fits where the part was originally supplied by Bosch?

*(*Mr. *Mantle.)* Of the companies I was thinking of, no.

Mr. Porter

68. To pursue the business of foreign penetration, does such increased foreign penetration (plus Austin Rover buying major components abroad) mean that even an increase in UK car output will be accompanied by a decline in the business available to UK component makers?

*(*Mr. *Cochlin.)* From Austin Rover's purchases?

69. I am talking of increased foreign penetration. What view does the Government take about the activities of Austin Rover and the decline in the UK content?

*(*Mr. *Cochlin.)* There has been some decline in the UK content of Austin Rover vehicles and the company would argue that it needed to make those switches to remain competitive; they were dealing with suppliers who were not able to offer what the competition was offering. I do not think it is yet a significant problem; it has certainly been the case in one or two instances, but no dramatic change has taken place in the level of purchasing which is highly British.

70. The Government is aware of a potential problem? The Government has views about almost everything, so it must have a view on this?

*(*Mr *Cochlin.)* Our hope is that the UK components sector will be able to maintain itself as an efficient, competitive supplier to Austin Rover. A switch need not occur. There is a danger if we do lose the competitive edge, but, as I say, there is no dramatic change yet in what seems a high UK content operation in the motor industry.

Chairman

71. When you financed BL did you lay down terms and conditions about how they should operate in terms of what component buy they should try to achieve, or did you leave the management decision to them?

*(*Mr *Cochlin.)* It is essentially a management decision.

72. So, you do not influence their purchasing?

*(*Mr *Cochlin.)* That is correct.

Mr Maxwell-Hyslop

73. What are the specific areas of weakness in the British components industry?

*(*Mr *Cochlin.)* I would not like to say whether there are whole areas of the industry which are necessarily weak.

74. Could you be more precise, because we have spent a lot of time this morning getting generalities from you; I am asking for some specifics. Are you saying there are no areas of weakness in the British components industry? If you say yes or no we can progress from there.

*(*Mr *Mantle.)* I hope it is not too much of a generalisation to say that the components industry certainly was weak in some respects and perhaps its problems in rectifying its weakness as quickly as some of its competitors lay in the area of manufacturing technology and quality.

Mr Maxwell-Hyslop: But I want specific points of weakness. Is the Department of Trade and Industry aware, or not aware, of any areas of weakness?

Chairman

75. If you look at the import penetration of components it is an extremely serious problem for British industry. You may choose not to give names in public, but are there particular companies of which you have knowledge which have suffered considerably in the line of production which they traditionally had based on the UK market?

*(*Mr *Cochlin.)* Yes. Clearly, we know of companies who are not showing signs of doing all the things necessary to be——

Mr Maxwell-Hyslop

76. In which components is most penetration being made, or are you not aware of that? Let us not waste each other's time. If you do not know, say so?

*(*Mr *Cochlin.)* I do not have that data.

77. None of you has it? Let us look at one example: fuel injection equipment. You are quite satisfied you are not aware of any areas of weakness. If you look at British cars fitted with direct fuel injection, are you likely to find it is British equipment rather than imported, or have you not noticed that?

*(*Mr *Brown.)* There is only one manufacturer in the world of fuel injection equipment; other companies make it under licence from Bosch, but that does not mean to say we are not aware of it. We may be helping a company to develop a competitive product.

78. Why was that not part of your answer to my question when I asked it without it being said for you?

*(*Mr *Brown.)* I did not know you wanted to get into such detailed specifics.

79. I thought I made it quite clear I wanted you to give specific information. I want to find out if you know what is happening, apart from anything else.

*(*Mr *Brown.)* I hope that by that answer we have indicated we know something about it.

Mr Maxwell-Hyslop: I have given you one example. Will you give us full particulars, if you possess them?

Chairman

80. If you do not have it, say so; if you can get it subsequently we would appreciate having it, because we want to find out the level at which you are operating?

*(*Mr *Cochlin.)* Perhaps we can take up your offer and let you have information on this, looking particularly at advice we can give you without actually in the process identifying their situations.

Mr Maxwell-Hyslop: On the contrary, if you are asked to identify them you will identify them. The witnesses are here to answer the Select Committee's specific questions.

Chairman: We quite understand that in terms of competition it might not make sense to make a public statement as to the positions of particular companies, but it can be done in private.

Mr Maxwell-Hyslop

81. We could go into private session if you have the knowledge but do not wish to impart it to us in public.

*(*Mr *Cochlin.)* My only concern was that your questions deserved better answers than we are able to give you today.

Chairman: It would be helpful if you could let us have that.

Mr Maxwell-Hyslop

82. Is the reason why our witnesses (who incidentally were chosen by the Department, not ourselves) cannot give the answer today the fact that they do not know?

*(*Mr *Cochlin.)* I do not have the information with me.

83. It is not of such concern to you that it is something you carry with you?

*(*Mr *Cochlin.)* Not the situation of an individual piece of componentry.

Mr Maxwell-Hyslop: Very illuminating!

Chairman: Do you have anything else?

Mr Maxwell-Hyslop: I think there is very little point in detaining the witnesses any longer.

Chairman

84. Turning to another item of government support (the fuel injection area was mentioned), I am sure you are conscious of the way in which the electronic manufacturing companies in this country are eager to get into the components market. You are giving support under the Support For Innovation (SFI) Scheme, the Micro-electronics Applications Project (MAP) and CAD/CAM Scheme to component manufacturers so that those who want to get into that market can attempt to do so?

*(*Mr *Cochlin.)* Yes. Since 1982–83 about £30 million worth of support for innovation has been offered to the components sector.

85. Have they taken it?

*(*Mr *Cochlin.)* Yes; they are specific projects which have been supported with the Department's help.

86. Would you be able to let us know the names of the companies concerned in confidence?

*(*Mr *Cochlin.)* Yes, of course.

87. Would you also be able to let us know how much money they have put in, because

[Chairman *Contd.*]

in some cases I believe you are looking for a partnership situation, not just straight money going into their businesses?

*(*Mr *Cochlin.)* Yes. Generally speaking, we contribute between one-quarter and one-third of the total project cost. The contribution has changed a bit.

88. It would be helpful if you could let us know the figures in terms of the support given to vehicle makers and component firms separately so we can see what it is, and also it would be useful if you could put alongside it the total amount of money which has been put into all industry under those programmes so we can see the percentages directed to those companies. In terms of the introduction of Flexible Manufacturing Systems, has there been assistance given to component manufacturers?

*(*Mr *Cochlin.)* Yes.

89. Will you also talk about that?

*(*Mr *Cochlin.)* Yes.

Mr Maxwell-Hyslop: Specifically, not as a new way of wasting time.

Chairman

90. I could speed up the process here, in that if you could let us have the same information relating to Flexible Manufacturing Systems it would be of assistance.

*(*Mr *Cochlin.)* By company?

Chairman: By the amount of money you are putting in and they are putting in, and also what are the objectives of these particular projects. We can add one more to your shopping list, because in paragraph 16 of your memorandum you say that the components industry has been a significant beneficiary of selective assistance under the Industrial Development Act. It would be useful if you could define it in quantitative terms, and we will let you have a statement of exactly what we want in writing.

Mr Maxwell-Hyslop: We may need to recall the witnesses, in which case they had better bring their Permanent Secretary with them so he is aware of the sort of answers they are able to supply to the Committee.

Chairman

91. Let us turn lastly to the question of the West Midlands. Is there a government policy to offer substantial assistance to West Midlands component firms?

*(*Mr *Cochlin.)* The West Midlands has been designated an assisted area which gives the opportunity for selective assistance which was not there before.

92. In that selective assistance are there any cases which you can quote, or quote to us in writing, where there has been direct assistance given?

*(*Mr *Cochlin.)* I am sure we can.

*(*Mr *Brown.)* In addition, you will be aware of the special West Midlands initiative which has been taken by one of our Ministers on AMT systems, and we could give you details of that.

93. Do you have any policy on rationalisation mergers and joint ventures? Do you encourage these in these in the motor components industry, and would you support such moves?

*(*Mr *Cochlin.)* I think the Government's position would be that the market will determine the scale and nature of rationalisation within the vehicle sector. It would be right to support particular ventures where there was an opportunity for it to be done successfully, but there is no policy of going out and taking the initiative in restructuring.

Chairman: Thank you. That brings us to the conclusion of our questions. We are looking for more information than you have been able to provide, and we are disappointed you have not been able to provide it today. I hope you will be able to give that information promptly.*

**Note:* Supplementary information provided by the Department of Trade and Industry is included with the Minutes of Evidence taken on 15 January 1986 (HC 91-ii).

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HOUSE OF COMMONS

TRADE AND INDUSTRY COMMITTEE

Session 1985-86

THE MOTOR COMPONENTS INDUSTRY

MINUTES OF EVIDENCE

Wednesday 15 January 1986

Department of Trade and Industry

Sir Brian Hayes, KCB, Mr M J A Cochlin, Mr A J Mantle and Dr R Butchart

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Members present:

Mr Kenneth Warren, in the Chair

Mr Bernard Conlan
Mr Stan Crowther
Mr Doug Hoyle
Mr Robert McCrindle
Mr Michael Martin
Mr Robin Maxwell-Hyslop
Mr Barry Porter
Mr Mike Woodcock

THE WEST MIDLANDS INITIATIVES

A Note submitted by the Department of Trade & Industry (M31)

At its hearing on 27 November, the Committee asked for guidance on the Department's promotional activity in the West Midlands.

THE 1983 INITIATIVE

2. The then Secretary of State for Trade & Industry announced on 21 March 1983 a number of initiatives particularly aimed at helping the West Midlands. These initiatives were:

(i) The re-opening of the Small Engineering Firms Investment Scheme (SEFIS 2) (SEFIS 1 was launched in March 1982 to help small engineering firms invest in advanced capital equipment. Under this £30 million scheme, the West Midlands received twice as much SEFIS support per head of population than the national average).

(ii) The establishment of a special team—"a Team for Innovation"—in the West Midlands Regional Office of the Department of Trade & Industry to help and encourage firms in the West Midlands to make the fullest use of all the national schemes of support for industry.

(iii) Assistance to the CBI, the Chambers of Commerce and local authorities to come together in partnership to co-ordinate and promote industrial and commercial developments in the region on a self-help basis.

(iv) The Government request to the English Industrial Estates Corporation to investigate the industrial property market in the West Midlands and to establish whether there was adequate provision for the needs of new industry and new and small businesses.

(v) The recruitment of a senior industrial adviser to lead the Team for Innovation.

(vi) The appointment of the Parliamentary Under-Secretary of State for Industry (Mr John Butcher) to take charge of the initiative.

3. The Secretary of State for Industry also announced that he would consider a modest grant in aid for the promotion of the region overseas in co-ordination with the Department's Invest in Britain Bureau. The regional CBI proposed the setting-up of an Industrial Development Association to promote investment opportunities and attract jobs into the West Midlands.

4. During the course of the initiative the Team for Innovation together with other West Midlands Regional Office staff made direct contact with some 2,700 firms. The table below

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gives the West Midlands percentage of the total UK applications for assistance under the various schemes:

NUMBER OF WEST MIDLANDS APPLICATIONS AS A PERCENTAGE OF NATIONAL TOTAL

SCHEME (see Annex 1, p.22)	*1982–83*	*1983–84*	*4 months 1984–85*
SFI	10.9	13.1	15.2
CADTES	9.6	14.6	—
MAP (C)	9.5	10.1	15.0
ROBOTICS/FMS	15.0	20.7	17.7
MAS	16.1	13.9	17.6
QAAS	—	16.8	17.7
DAS	17.2	17.3	15.8
TES	13.6	15.0*	17.1
MISP/FOS	3.0	1.5	5.9
MAPCON	9.1	9.9	7.1

* 10 months.

5. The Table indicates a general improvement in the percentage of scheme "take" in the West Midlands during the promotional period of the initiative. This was particularly so in relation to the schemes which apply to the smaller firm and which have had, therefore, the concentration of effort during the period ie SFI, QAAS, DAS and TES.

6. A major feature of the intiative was the Government's financial support of £70 million for the area's industry. This money was used to equip hundreds of local companies, large and small, with new technology and improved production facilities to enable them to meet international competition. The Government grants triggered a much greater spending by industry itself—more than £200 million in all on innovative projects.

Designation of West Midlands as an Assisted Area

7. The initiative was largely succeeded by the designation of much of the West Midlands[1] as an Assisted Area with Intermediate Area Status on 29 November 1984. As an Intermediate Area much of the region is eligible for, in addition to assistance under Section 8 of the Industry Act 1982, the following financial assistance:

(i) Regional Selective Assistance under Section 7 of the Industry Act 1982;

(ii) Training grants, and may be eligible for:

(iii) European Regional Development Fund grant;

(iv) European Social Fund grants;

(v) Medium long-term loans from the European Investment Branch or from the European Coal and Steel Community.

Initiative on Advanced Manufacturing Technology

8. Following grant of Assisted Area status, a further Government initiative to promote the introduction of Advanced Manufacturing Technology (AMT) in the West Midlands was launched on 22 April 1985. Up to £5 million of the £55 million allocated to the Flexible Manufacturing System Scheme was set aside to assist companies with operations in the West Midlands to establish AMT facilities within the region. Companies were invited to compete for grants of up to 20 per cent of the cost of installing Advanced Manufacturing Technology. The aims of the initiative were first to make the West Midlands a showcase for AMT by helping to establish a series of demonstrations in a working environment in 5–10 companies along the Rugby–Telford axis. Second, it recognised the need to revitalise the West Midlands as the heartland of UK manufacturing industry. Third, it was designed

[1] The travel to work areas of Coventry & Hinckley, Birmingham, Walsall, Dudley and Sandwell, Wolverhampton, Kidderminster, Telford and Bridgnorth.

to encourage industry in the region to help itself regain international competitiveness and seek new market opportunities at home and abroad by adopting modern manufacturing techniques and management practices.

9. After the launch of the AMT initiative some 50 companies attended an AMT workshop in May 1985 which was organised by the Department and held at the Engineering Employers' Association in Birmingham and a further 14 companies attended six "surgeries" at the Department's West Midlands Regional Office.

10. The initiative resulted in 19 companies submitting applications for projects with total costs amounting to some £31 million before the closing date for applications which was 30 September 1985. A list of applicants is attached at Annex 2*; of these 4 applicants are concerned with, inter alia, components supply. One (Jaguar Cars Ltd) is a vehicle assembler seeking assistance to improve its "in-house" engine component technology.

ASSISTANCE TO THE MOTOR COMPONENTS INDUSTRY IN THE WEST MIDLANDS

11. Annual figures showing financial assistance to the motor components industry in the West Midlands are not readily available. However, at Annex 3* is a summary of the financial assistance offered under the Department of Trade & Industry's SFI, MAP and CADTES Schemes to:

(i) the West Midlands;

(ii) motor components industry in the West Midlands;

(iii) the vehicle assembly industry in the West Midlands.

The financial assistance under the Schemes taken up to date is also shown.

12. At Annex 4* is similar information in respect of financial assistance offered to the West Midlands under Section 7 of the Industry Act 1982 following the designation of much of the region as an Assisted Area on 29 November 1984. In addition the motor component suppliers which have received this assistance are listed. Annex 5* covers financial assistance offered to major automotive companies in the West Midlands under Section 8 of the Industry Act.

December 1985

* Not reported.

Annex 1

WEST MIDLANDS INITIATIVE
DEFINITION OF TERMS

SFI	Support for Innovation
CADTES	Computer Aided Design and Test Equipment Support
MAP (C)	Microelectronics Application Project
FMS	Flexible Manufacturing Scheme
MAS	Manufacturing Advisory Service
QAAS	Quality Assurance Advisory Service
DAS	Design Advisory Service
TES	Technical Enquiry Service
MISP/FOS	Microelectronics Industry Support Programme/Fibre Optics and Opto-Electronics Scheme
MAPCON	Microelectronics Application Consultancy Support

FINANCIAL ASSISTANCE TO MAJOR AUTOMOTIVE COMPONENT SUPPLIERS

A Note Submitted by the Department of Trade and Industry (M32)

At its meeting on 27 November, the Committee asked for information relating to assistance given to automotive component manufacturers namely:—

(i) What proportion of the Support for Innovation (SFI), the Microelectronics Applications Project (MAP) and CAD/CAM Schemes went to:—

(*a*) vehicle makers
(*b*) component companies

and what were the sums involved? These details are set out in Tables B and C attached.

(ii) How much has been given to assist the introduction of Flexible Manufacturing Systems (FMS) in component companies? How many projects are involved, and where? These details are set out in Table D attached.

(iii) How much has been given to component companies under the Industrial Development Act 1982 and how many projects have been involved? These details are set out in Table E attached.

A compilation of these three sets of figures for the component suppliers is at Table A.

Since there is no identifiable industrial classification into which automotive component suppliers fall the figures in the Tables that follow derive from a search of Departmental records by company name. The field of search was defined as companies or groups with identifiable automotive turnover over £10 million pa; 68 such companies or groups were identified covering over 500 individual companies.

Where possible the figures extracted are for the last full five years. However in the case of the Support for Innovation Scheme (SFI) including its predecessor Product Process Development Scheme (PPDS) and the Microelectronics Applications Project (MAP) figures have only been extracted for the years for 1982–83 from which time the details have been included in the Department's computer database.

In summary the total amount of selective assistance offered to major automotive component companies from 1982–83 in response to applications made under the various schemes of selective assistance is £53.9 million of which £16.9 million has been paid.

13 *January* 1986

TABLE A

SUMMARY OF ASSISTANCE TO AUTOMOTIVE COMPONENT SUPPLIERS

	1982–83—30 November 1985 £m	
	Amount offered	*Assistance Paid to date*
Support for Innovation (SFI)	16.8	8.3
Microelectronics Application Project (MAP)	0.8	0.5
Computer Aided Design & Test Equipment Support (CADTES)	0.9	0.8
Flexible Manufacturing Systems (FMS)	5.6	2.8
Section 7 of the Industrial Development Act	25.6	3.0
Section 8 of the Industrial Development Act (General Facility)	2.8	0.4
Fibre Optics and Opto-Electronic Scheme (FOS)	1.3	0.9
Microelectronics Industry Support Programme (MISP)	0.2	0.1
Small Engineering Firms Investment Scheme (SEFIS)		
	53.9	16.9
Note: Support for Innovation given by Vehicles Division to those companies with an automotive turnover of *under £10 million.*	3.9	1.5
Subsequent enhanced total	57.8	18.4

TABLE B

SUPPORT FOR INNOVATION (SFI), COMPUTER AIDED DESIGN AND TEST EQUIPMENT SUPPORT (CADTES)[1] AND MICROELECTRONICS APPLICATION PROJECTS (MAP): ASSISTANCE OFFERED TO THE AUTOMOTIVE INDUSTRY BY YEAR AND TOTAL PAID OVER THE PERIOD FROM APRIL 1982 TO 30 NOVEMBER 1985 ON THE OFFERS

£m

Scheme	*Offers Made*[2]				*Total Paid*
	1982–83	*1983–84*	*1984–85*	*1985–86*	
SFI	13.9	9.3	5.0	0.9	12.1
MAP	0.7	0.2	—	—	0.5
CADTES	0.2	0.5	0.4	—	0.9
TOTAL	14.8	10.0	5.4	0.9	13.5

Notes

[1] CADTES was introduced in August 1982 and was an extension of computer aided design/computer aided manufacture (CAD/CAM)

[2] Offers include those projects which are on going and will therefore attract further payments

TABLE C

SFI, CADTES AND MAP ASSISTANCE OFFERED AND PAID TO THE MAJOR AUTOMOTIVE COMPANIES BY SECTOR

£m

	Offers Made[2]				*(A) Total Paid*	*(B) Total Department Assistance Paid*	*(A) as a% of (B)*
	1982–83	*1983–84*	*1984–85*	*1985–86*			
COMPONENT SUPPLIERS							
SFI[3]	5.2	7.0	4.1	0.5	8.3	308.9	2.7% (3.2%)[6]
MAP[4]	0.7	0.1	—	—	0.5	26.0	1.9%
CADTES[1,5]	0.2	0.4	0.3	—	0.8	21.5	3.6%
VEHICLE ASSEMBLERS							
SFI	7.7	2.2	0.8	0.2	2.9		1.0% (1.3%)[6]
MAP	—	0.1	—	—			0.1%
CADTES	—	—	neg[7]	—	neg[7]		0.1%
TRACTORS							
SFI	0.3	0.2	0.1	0.1	0.4		0.1% (0.3%)[6]
MAP	—	—	—	—	—		—
CADTES	—	neg[7]	neg[7]	—	neg[7]		0.2%
CONSTRUCTION EQUIPMENT							
SFI	0.7	—	0.1	—	0.4		0.1%
MAP	—	—	—	—	—		—
CADTES	—	0.1	—	—	0.1		0.3%
TOTAL DEPARTMENT							
SFI	151.2	222.5	118.6	30.2			
MAP	15.2	16.4	4.8	1.0			
CADTES	6.6	14.0	3.4	—			

Notes:

[1] CADTES was introduced in August 1982 and was an extension of computer aided design/computer aided manufacture (CAD/CAM)
[2] Offers include those projects which are on going and will therefore attract further payments
[3] SFI assistance is made under Section 5 of the Science & Technology Act 1965.
[4] MAP assistance is made under Section 5 of the Science & Technology Act 1965.
[5] CADTES assistance is made under Section 8 of the Industrial Development Act 1982.
[6] Figures in brackets in final column of Table C use the enhanced SFI figures—see footnote to Table A
[7] neg = negligible

TABLE D

ASSISTANCE GIVEN TO MAJOR COMPONENT SUPPLIERS UNDER SECTION 8 OF THE INDUSTRIAL DEVELOPMENT ACT 1982 TO ASSIST THE INTRODUCTION OF FLEXIBLE MANUFACTURING SYSTEMS (FMS)[1] SINCE THE SCHEME'S INTRODUCTION IN JUNE 1982

£m

Region	*1982–83*	*1983–84*	*1984–85*	*1985–86*	*Total Assistance Paid*
Scotland: No of offers	—	1	1	—	0.1
Value of offers (£)	—	0.1	0.1	—	
Wales: No of offers	—	—	—	—	—
Value of offers (£)	—	—	—	—	
East Midlands: No of offers	1	2	—	—	0.5
Value of offers (£)	0.1	0.5	—	—	
North West: No of offers	—	2	1	—	0.3
Value of offers (£)	—	0.1	0.4	—	
South West: No of offers	1	10	—	—	0.8
Value of offers (£)	0.1	1.3	—	—	
North East: No of offers	1	1	—	—	0.1
Value of offers (£)	0.1	0.1	—	—	
Yorkshire & Humberside: No of offers	—	—	1	—	0.4
Value of offers (£)	—	—	1	—	
West Midlands: No of offers	1	4	1	1	0.4
Value of offers (£)	0.4	0.6	0.1	0.2	
South East: No of offers	1	1	1	—	0.3
Value of offers (£)	0.1	0.2	0.1	—	
Total: No of offers	5	21	5	1	2.8
(a) Value of offers (£)	0.7	2.9	1.7	0.2	
Total Department: No of offers	49	130	75	26	18.3
(b) Value of offers (£)	5.0	21.0	17.3	2.9	
(a) as a percentage of (b)	14.9%	13.9%	9.8%	7.3%	15.5%

Note:

[1] FMS includes Robotic projects

TABLE E

SELECTIVE ASSISTANCE UNDER THE INDUSTRY ACT 1972 AND THE INDUSTRIAL DEVELOPMENT ACT 1982 TO MAJOR COMPONENT SUPPLIERS

£m

		1980–81	*1981–82*	*1982–83*	*1983–84*	*1984–85*	*1985–86*	*Total Assistance Paid*
SECTION 7	No of offers	8	2	10	12	6	12	
	(£) Value of offers	7.4	1.1	6.8	5.4	5.1	8.3	8.4
SECTION 8 (excluding CADTES & FMS)								
(i) General facility, SIS[1] and ILIS[2]	No of offers	7	4	2	4	3	1	
	(£) Value of offers	3.9	4.6	0.4	1.5	0.5	0.4	7.1
(ii) FOS[3]	No of offers	—	—	—	2	1	—	
	(£) Value of offers	–	—	—	0.6	0.7	—	0.9
(iii) MISP[4]	No of offers	—	—	—	1	—	—	
	(£) Value of offers	—	—	—	0.1	—	—	0.1
(iv) SEFIS[5]	No of offers	—	—	—	1	1	—	
	(£) Value of offers	—	—	—	neg[6]	neg[6]	—	neg[6]
Total	No of offers	15	6	12	20	11	13	
	(£) Value of offers	11.3	5.7	7.2	7.6	6.4	8.7	16.6

Notes:

[1] SIS = Selective Investment Scheme
[2] ILIS = Innovation Linked Investment Scheme
[3] FOS = Fibre Optics and Opto-Electronics Scheme
[4] MISP = Microelectronics Industry Support Programme
[5] SEFIS = Small Engineering Firms Investment Scheme
[6] neg = negligible

	Date Scheme Introduced	*Date Scheme Closed*
SIS	15.12.76	30.6.79
ILIS	1.6.83	22.5.84
FOS	27.7.82	on going
MISP	26.7.78	on going
SEFIS	30.3.82	30.9.83

HEAVY COMMERCIAL VEHICLES

A note submitted by the Department of Trade and Industry (M33)

At its meeting on 27 November, the Committee asked whether heavy commercial vehicles were more component intensive than cars and car-derived vans. The following guidance reflects advice which the Department has received from vehicle assemblers.

2. In broad terms, the average number of components on a heavy commercial vehicle is 2,500, on cars 2,200 and on car-derived vans 2,000. Expressed as a percentage of the ex-works price of the vehicle, between 35–40 per cent of the value of the car and car-derived van is represented by out-sourced components ie components not produced by the assembler in-house or by an affiliate of the assembler. The percentage would be slightly higher in respect of heavy commercial vehicles.

3. The above is intended to provide the Committee with a rough guide to the significance of bought-in components within an assembler's operations. Obviously the percentage will vary between assemblers and between particular models.

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MOTOR COMPONENTS MANUFACTURERS TRADING OVERSEAS

Supplementary information submitted from the Department of Trade and Industry (M34)

1. At the Hearing on 27 November the Select Committee asked officials for guidance on the percentage of the motor components industry now operating abroad. No official statistics are available but the Committee may find the following information helpful.

2. Table 1 is an alphabetical list of those automotive components suppliers operating in the UK which on the basis of the information available to the Department have an automotive turnover in excess of £10 million per annum. These suppliers are not all UK-owned. Table 2 lists those that are in alphabetical order, and indicates inter alia those with overseas manufacturing facilities.

3. Table 3 lists the remaining companies. These are foreign owned and the table shows the location of the parent company.

4. It is not possible to give a percentage based on these figures since the proportions of UK and overseas business are not known to the Department. Nor do the tables include the component manufacturing carried out by the Vehicle Assemblers.

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TABLE 1

LIST OF COMPANIES WITH AUTOMOTIVE COMPONENT MANUFACTURING INTEREST OF MORE THAN £10 MILLION PER ANNUM

Company	*Products Include*
Adwest Group plc	Steering equipment, linear controls, pumps, seat mechanisms
AE plc	Block head and crankcase components, cylinder components, valve train
Alcan	Aluminium products
Allied Corporation	Air brake equipment and associated compressed air equipment
American Standard	Air and vacuum braking, heat exchanger tubes, air and oil coolers
Armstrong Equipment	Suspension components, steering columns, cab-tilt hydraulics
Automotive Products	Gearboxes, braking systems, clutches, pump, steering and suspension
Avon Rubber	Tyres, engine mounts, rubber products

Company	*Products Include*
BBA Group	Friction materials, fan belts
Birmid Qualcast	Gearbox castings, crankshafts, cylinder heads
Borg Warner	Air conditioning, transmissions, clutches
British Timken	Tapered roller bearings
BSG International	Seat belts, sun roofs, lighting, seals
BTR	Radiators, wheels, carpets, reinforced plastic, fuel tanks
Burmah Oil	Clutches, hydraulic equipment, hoses, couplings, fan belts
Camford Engineering	Axles, crossmembers, steering arms, brake pipes, shoes and drums
Champion	Spark plugs
Chloride	Batteries
Concentric	Oil and water pumps, torsional vibration dampers
Courtaulds	Textiles, plastics
Cummins	Diesel engines
Dana	Axles, transmissions, universal joints
Dowty Group	Pressings, hydraulic seals, rubber and plastic mouldings
Duport	Metal forming, plastics
Eaton	Axles, brakes and gearboxes
Evered Holdings	Transmissions, suspensions, castings
Edbro	Hydraulic tipping equipment
George Fischer	Malleable iron and plastic tube fittings
GKN	Transmission equipment, axles, engine parts, springs, couplings, wheels
Goodyear	Tyres, fan belts, hoses
Hawker Siddeley	Diesel engines, sensors, suspensions, batteries, electrical equipment
Hanson Trust	Heating equipment
Hoover Universal	Seating components
ICI	Paints and protective coatings
IMI	Radiators, carburettors, vehicle number plates
Jonas Woodhead	Springs and suspension equipment
Lucas Industries	Braking and fuelling systems, electrical and electronic components
Manganese Bronze	Bodywork for taxis, metal components and assemblies
Marley	Crash pads, seating foam, interior trim mouldings
Marmon Group	Seat belts, components and mechanisms
Massey Ferguson	Diesel engines
Matra	Carburettors, LPG systems
Michelin	Tyres, tubes, wheels and accessories
Pilkington Glass	Safety Glass
Rearsby	Pedal boxes, clutch plates, steering columns, handbrakes
RHP Bearings	Bearings, fasteners
Rubery Owen	Trailer axles, suspension and braking systems
Rockwell	Axles and axle assemblies
SKF	Bearings
Tecalemit	Filters, lubrication systems
Trico-Folberth	Windscreen wiper blades, arms, motors, washers and accessories
TRW	Steering and suspension, electronics, fasteners, engine valves
TI Group	Exhaust systems, suspension, brake and seating equipment
Turner and Newall	Brake and clutch linings, gaskets and filters
Uniroyal	Rubber products (non-tyre)
Uniroyal-Englebert	Tyres
Wardle Storey	Interior trim and sound insulation, sun visors
Williams Holdings	Automotive castings, chains

TABLE 2

	UK Component Company	*Location of Overseas Automotive Manufacturing Facilities*
1	Adwest Group plc	France, India, Spain, Tunisia
2	AE plc	Belgium, France, Netherlands, South Africa, USA, West Germany, Italy
3	Armstrong Equipment plc	Canada, Spain
4	Automotive Products	Belgium, France, Italy, USA
5	Avon Rubber plc	Australia, Canada, Switzerland, USA, West Germany
6	BBA Group	France, Canada, South Africa, West Germany, Sweden, Belgium
7	Birmid Qualcast	*
8	BSG International plc	France, West Germany
9	BTR plc	Australia, New Zealand
10	Burmah Oil	Australia, South Africa
11	Camford Engineering	*
12	Chloride	Norway, Sweden, Denmark, Italy, Malawi
13	Concentric	*
14	Courtaulds	*
15	Dowty Group	Canada, USA, West Germany
16	Duport	*
17	Edbro	*
18	Evered Holdings	South Africa, USA
19	GKN plc	West Germany, USA, France
20	Hanson Trust	*
21	Hawker Siddeley	Australia, Spain, France, USA, India
22	ICI plc	*
23	IMI plc	Spain, South Africa, USA
24	Jonas Woodhead	Eire, India
25	Lucas Industries	France, West Germany, Spain, USA, Australia, Brazil, Canada, India, South Africa
26	Manganese Bronze	*
27	Marley plc	*
28	Pilkington Glass Ltd	Eire, Sweden, Finland, Brazil, Australia, New Zealand, South Africa
29	Rearsby Automotive	*
30	RHP Bearings Ltd	Australia, Canada, France, South Africa, USA
31	Rubery Owen	Australia, India
32	Tecalemit	France, West Germany, India, Australia, USA
33	TI Group	Canada, Spain, Netherlands
34	Turner and Newall	Spain, France, Italy, West Germany, USA, South Africa, India, New Zealand, Hong Kong
35	Wardle Storey plc	*
36	Williams Holdings plc	*

* As far as known these companies do not have overseas *automotive* manufacturing facilities.

TABLE 3

TOP FOREIGN-OWNED AUTOMOTIVE COMPONENT MANUFACTURERS IN THE UK

Group		*Location of Parent Company*
1	Alcan	Canada
2	Allied Corporation (Bendix)	USA
3	American Standard (Clayton-Dewandre)	USA
4	Borg-Warner	USA
5	British Timken	USA
6	Champion	USA
7	Cummins	USA
8	Dana	USA
9	Eaton	USA
10	George Fischer	Switzerland
11	Goodyear	USA
12	Hoover Universal	USA
13	Marmon Group plc (ASE(UK)LTD)	USA
14	Massey Ferguson	Canada
15	Matra (Solex(UK)Ltd)	France*
16	Michelin	France
17	Rockwell	USA
18	SKF	Sweden
19	Trico-Folberth	USA
20	TRW	USA
21	Uniroyal-Englebert Ltd	West Germany
22	Uniroyal Ltd	USA

* The UK company is in receivership.

TRADE IN MOTOR VEHICLE COMPONENTS

A note submitted by the Department of Trade and Industry (M35)

At its meeting on 27 November, the Committee asked for information on trade in motor vehicle components additional to that contained in Table 4 of the Department's original memorandum, namely:

(i) to provide the ratio of exports of components (by value) to imports for each year covered. These details are set out in the revised Table 4 attached;

(ii) to provide the same information expressed in constant prices. This is now set out at Table 4A attached;

2. The Committee also asked about the statistical treatment of shipments of goods classifed as KD kits. These shipments are not included under the heading of components but are included under the appropriate vehicle heading. Thus, for passenger cars, kits are recorded under "Cars and Taxis" as unassembled vehicles. Table 4B and 4C attached show separately the exports and imports of assembled and unassembled cars at current and constant prices respectively. Tables 4D and 4E show under the heading "Chassis" the nearest equivalent to unassembled cars in respect of commercial vehicles. This information is again given at current and constant (1980) prices.

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TABLE 4 (Revised)
[Original table was published in HC 91–i page 6]

TRADE IN MOTOR VEHICLE COMPONENTS

Region									(£ million at current price)
UK EXPORTS TO:	*1975*	*1976*	*1977*	*1978*	*1979*	*1980*	*1982*	*1983*	*1984*
EEC	387	587	742	797	904	927	976	1,020	1,119
SPAIN	9	17	22	26	25	32	63	83	134
EFTA	179	200	213	212	245	266	229	199	204
USA	121	166	164	155	183	174	111	194	260
JAPAN	5	5	6	6	8	7	6	7	9
OTHERS	450	529	495	547	548	638	565	516	599
TOTAL EXPORTS	1,151	1,504	1,642	1,743	1,913	2,044	1,950	2,019	2,325
UK IMPORTS FROM:									
EEC	279	429	548	668	884	736	1,050	1,381	1,462
SPAIN	8	17	28	26	20	35	62	73	99
EFTA	25	32	33	34	62	57	78	97	117
USA	47	66	62	60	72	71	82	88	101
JAPAN	16	20	41	42	52	36	115	136	157
OTHERS	21	38	45	47	59	56	82	117	159
TOTAL IMPORTS	396	602	757	877	1,149	991	1,469	1,892	2,095
BALANCE	755	902	885	866	764	1,053	481	127	230
RATIO BY VALUE OF EXPORTS TO IMPORTS	2.9	2.5	2.2	2	1.7	2.1	1.3	1.1	1.1

Source: Society of Motor Manufacturers and Traders.

Notes:
1 The components covered by the Society's data are close to those embraced by the definition of components in this paper and provide a more appropriate indicator of trade levels than the figures available under the more restricted SIC definition.
2 No figures for 1981: strike action that year affected the availability of complete data.

TABLE 4A

TRADE IN MOTOR VEHICLE COMPONENTS

(£ million constant 1980 prices)

REGION									
UK EXPORTS TO:	*1975*	*1976*	*1977*	*1978*	*1979*	*1980*	*1982*	*1983*	*1984*
EEC	788	989	1,067	1,053	1,030	927	802	740	743
SPAIN	18	29	32	34	28	32	52	60	89
EFTA	364	337	306	280	279	266	188	144	136
USA	246	280	236	205	208	174	91	141	173
JAPAN	10	8	9	8	9	7	5	5	6
OTHERS	916	891	712	722	624	638	465	374	398
	2,342	2,534	2,362	2,302	2,178	2,044	1,603	1,464	1,545
UK IMPORTS FROM:									
EEC	521	781	772	681	871	736	946	1,147	1,143
SPAIN	15	31	39	27	20	35	56	61	77
EFTA	47	58	46	35	61	57	70	81	91
USA	88	120	87	61	71	71	74	73	79
JAPAN	30	36	58	43	51	36	104	113	123
OTHERS	39	69	63	48	58	56	74	97	124
	740	1,095	1,065	895	1,132	991	1,324	1,572	1,637
RATIO BY VALUE OF EXPORTS TO IMPORTS	3.2	2.3	2.2	2.6	1.9	2.1	1.2	0.9	0.9

Source: Society of Motor Manufacturers and Traders adjusted by DTI to 1980 constant prices.

Notes:

1 The components covered by the Society's data are close to those embraced by the definition of components in this paper and provide a more appropriate indicator of trade levels than the figures available under the more restricted SIC definition.

2 No figures are shown for 1981: strike action that year affected the availability of complete data.

TABLE 4B

UNITED KINGDOM TRADE IN PASSENGER CARS

£ million Current Prices

	1975	*1976*	*1977*	*1978*	*1979*	*1980*	*1982*	*1983*	*1984*
Exports									
Assembled	315	455	533	668	582	582	732	783	878
Unassembled	168	179	219	255	235	237	201	176	120
TOTAL	483	634	752	923	817	819	933	959	998
Imports									
Assembled	514	871	1,305	1,765	2,581	2,098	2,876	3,649	3,662
Unassembled	219*	15	19	16*	190*	31*	31*	54*	16*
TOTAL	514	886	1,324	1,765	2,581	2,098	2,876	3,649	3,662
BALANCE—Deficits shown in brackets	(31)	(252)	(572)	(842)	(1,764)	(1,279)	(1,943)	(2,690)	(2,664)
TRADE RATIO—By value of exports to imports	0.94	0.72	0.57	0.52	0.32	0.39	0.32	0.26	0.27

Source: Customs & Excise through SMMT publications

* These figures are in £000's

TABLE 4C

UNITED KINGDOM TRADE IN PASSENGER CARS

£ million Constant 1980 Prices

	1975	*1976*	*1977*	*1978*	*1979*	*1980*	*1982*	*1983*	*1984*
Exports									
Assembled	645	763	721	792	631	582	598	560	577
Unassembled	343	300	296	303	255	237	164	126	79
TOTAL	988	1,063	1,017	1,095	886	819	762	686	656
Imports									
Assembled	990	1,248	1,657	1,985	2,675	2,098	2,320	2,642	2,528
Unassembled	422*	22	24	18*	197*	31*	25*	39*	11*
TOTAL	990	1,270	1,681	1,985	2,675	2,098	2,320	2,642	2,528
TRADE RATIO—By value of exports to imports	1.0	0.84	0.60	0.55	0.33	0.39	0.33	0.26	0.26

* These figures are in £000's

TABLE 4D

UNITED KINGDOM TRADE IN COMMERCIAL VEHICLES
(Vans, Trucks, Artics & Buses)

£ million Current Prices

	1975	*1976*	*1977*	*1978*	*1979*	*1980*	*1982*	*1983*	*1984*
Exports									
Complete	404	522	598	487	531	536	466	388	328
Chassis	24	26	55	67	87	89	52	50	61
TOTAL	428	548	653	554	618	625	518	438	389
Imports									
Complete	X	117	209	258	365	352	407	565	654
Chassis	X	6	2	3	8	8	10	10	5
TOTAL	90	123	211	261	373	360	417	575	659
BALANCE—Deficits shown in brackets	338	425	442	293	245	265	101	(137)	(270)
TRADE RATIO—By value of exports to imports	4.76	4.46	3.09	2.12	1.66	1.74	1.24	0.76	0.59

Source: Customs & Excise through SMMT publications
Note: 'X' indicates that the information is not separately available.

TABLE 4E

UNITED KINGDOM TRADE IN COMMERCIAL VEHICLES
(Vans, Trucks, Artics & Buses)

£ million Constant 1980 Prices

	1975	*1976*	*1977*	*1978*	*1979*	*1980*	*1982*	*1983*	*1984*
Exports									
Complete	818	816	775	564	565	536	413	304	248
Chassis	49	41	71	78	93	89	46	40	46
TOTAL	867	857	846	642	658	625	459	344	294
Imports									
Complete	X	169	260	294	377	352	360	469	517
Chassis	X	8	2	3	8	8	9	8	4
TOTAL	168	177	262	297	385	360	369	477	521
TRADE RATIO—By value of exports to imports	5.16	4.84	3.23	2.16	1.71	1.74	1.24	0.72	0.56

Note: 'X' indicates that the information is not separately available.

Examination of Witnesses

SIR BRIAN HAYES, KCB, Permanent Secretary, MR M J A COCHLIN, Grade 3, Head of Vehicles Division, MR A J MANTLE, Grade 5, Vehicles Division, and DR R BUTCHART, Statistician, Statistics Division 1, Department of Trade and Industry, called in and examined.

Chairman

94. This morning we resume our inquiry into the motor components industry and in particular this morning the role of the Department of Trade and Industry. Sir Brian, how much of your time do you spend dealing with issues relating to the motor components industry?

*(*Sir *Brian Hayes.)* Chairman, if I interpret that question narrowly and relate it to the time spent on particular issues relating exclusively and directly to the motor components industry, the answer would be very little, probably not more than four or five hours in the course of a year. But if I interpret it rather more widely so as to include time spent on issues which have direct implications for the components industry, the answer would, of course, be much more. I spend a lot of time on issues relating to vehicle assembly, manufacture, matters such as BL's corporate plan, and our contacts with the assemblers on local content or vehicle emission questions and that kind of thing, all of which have direct relevance to the motor components industry, but the particular issues affecting the industry, and particularly those of grants under our various schemes, would be handled by the sponsoring division, would be under the control of Ministers who would necessarily be involved more. I would, however, see any submissions the division made to Ministers because I see all submissions to Ministers, and that gives me an opportunity to intervene if that seems desirable. I do try and keep in touch with the industry. I have visited Lucas, for example, and some of the smaller component industries in the West Midlands. I have had talks quite recently with the Chairman of AE and the President of Cummins. One likes to keep in touch as far as possible, but as far as time spent directly on policy issues relating exclusively to components is concerned, very little time.

95. How many officials do you have in the Department dealing with the motor components industry specifically?

*(*Sir *Brian Hayes.)* There are eight officials of the grades from Executive Officer up to Principal who are occupied full-time or very nearly so on component issues, then there are three who are occupied with sponsorship of the engine companies and spend a great proportion of their time on automotive-related and general matters. That makes 11 altogether, and the Head of the Branch, Mr Mantle, and the Head of the Division also spend significant amounts of time on component matters, about 60 per cent in Mr Mantle's case and 20 per cent in Mr Cochlin's case. But that is only the people in the Vehicles Division. Throughout the Department I suppose there are perhaps 60 other people who in the course of their involvement in other industrial sectors have contacts with firms who number the automotive industry among their customers, and people who deal with castings, forgings, pressings, rubber, glass, ceramics, textiles, and plastics, would have contacts through their own sponsoring divisions with companies in those fields, but as far as the people concerned almost exclusively with vehicle components are concerned, the number would be 11.

96. Have the numbers varied in the last five to ten years?

*(*Sir *Brian Hayes.)* Five years ago there were 11. The number was then reduced, not surprisingly perhaps, because we were reducing numbers throughout the Department, and they went down to nine in 1983, but then we had a surge of applications for support and innovation assistance and we had to increase that number back to 11 early in 1984 and we have 11 people there now. I should perhaps add that we do try and keep people in that sort of job for, say, four years at a time because I think it is very upsetting to their clients in industry if there are constant changes.

97. How often do these officials visit the industry?

*(*Sir *Brian Hayes.)* During 1985 Vehicles Division staff made about 400 company visits. that is exclusive of contacts made at conferences, exhibitions, industry functions and so on. I do encourage this, not just visiting for the sake of visiting. They need to have a specific purpose in visiting a company

[Chairman *Contd.*]

but when they do visit a company they take the opportunity of discussing the situation generally with the people there and finding out all they can about the company concerned. Of course, they use exhibitions and fairs and so on as a means of making contact in much the same way. I should perhaps say I do believe that it is an essential part of the job of the DTI to know its industries. That is not because we seek to dictate to them, to restructure them, to run them in any way, but if we are to perform our function, which is to help those industries to become more competitive, efficient and successful, we need to know them well and we seek to do so.

Mr Maxwell-Hyslop

98. Sir Brian, do you share the same complacency as that evinced by your Department's witnesses at the last hearing on this subject as to performance and prospects of the British motor vehicle components industry? If you do not would you tell the Committee why they were unable to say in specific detail what causes you particular anxiety in the British motor vehicle components industry?

*(*Sir *Brian Hayes.)* Yes, as far as I can, and I will explain that remark a little later. First of all, I would reject the charge that the witnesses at the last meeting showed complacency about the future of the industry. I have read the transcript of that hearing and I do not believe it would bear out that accusation.

99. If they were ignorant of any shortcomings they must be complacent about them, must they not? You cannot be worried about something you are unaware of?

*(*Sir *Brian Hayes.)* That is perfectly true but they are not ignorant about the shortcomings. Why they did not answer specific questions which Mr Maxwell-Hyslop in particular raised about the shortcomings of the industry is that our knowledge of shortcomings is based very largely on information given to us in confidence by companies. We have a relationship with companies in this as in every other industry which is based entirely on mutual confidence and trust. Those companies tell us things we are simply not free to repeat, and it was when we were asked to single out sectors of the industry which are showing weaknesses or difficulty that that delemma arose for the officials giving evidence. If one stops to think for a moment one recognises that there are really two factors here. There is first the factor of confidentiality, which is a real bar on our speaking freely about this kind of thing, and the second factor is when one is talking here about a particular sector of the industry one is very often talking essentially about one company or perhaps two companies and making remarks about the weaknesses of one company or perhaps two that can have an effect on that company on the Stock Exchange and more widely, which would be damaging and which we have no right to do.

100. But your witnesses were offered the opportunity of going into private session, which would have dealt wholly with the point you have made. The answer they gave was that they did not have the information in their possession.

*(*Sir *Brian Hayes.)* It would deal satisfactorily with the second point I made. It would not deal satisfactorily with the question of confidentiality. When someone tells me something in confidence he does not expect me to repeat it outside, even in confidence, even to people who are 100 per cent trustworthy. That is what confidence means. The information we have is not information we are allowed to pass on.

101. Sir Brian, are you telling us that the range of components not produced in this country is a matter so secret that your witnesses cannot share it with this Committee in private session? Are you really inviting the Committee to believe that, that knowledge of whether there are automatic gearboxes produced in this country or gas-filled shock absorbers or suspension units is a matter so unknown and so secret that although officials were aware of it—and they denied they were—they were prepared to defy the Committee and not give it in private session? Are you really inviting the Committee to believe that?

*(*Sir *Brian Hayes.)* As the question is phrased, no, I am not, but the question is a question about negatives. What my officials are very well aware of are the positive facts about the industry. They know what is made here. To be asked to give a long description of what is not made here is much more difficult.

102. That is with 11 men monitoring the industry they are not aware of its shortcomings?

*(*Sir *Brian Hayes.)* Given notice, they could perfectly well produce a list of items of equipment produced in this country. It is not,

[Mr Maxwell-Hyslop *Contd.*]
I think, reasonable to expect them to do that off the cuff.

Mr Hoyle

103. Sir Brian, if I may follow up the charge of complacency, what appeared to be coming out of the last meeting was that there are indigenous manufacturers who use quite a large amount of local components but it also seemed to be underlined that there was not a knowledge of what future policy would be in relation to these companies, whether that would be an increasing trend or a declining trend. There is the fact that some of these companies are now having to look outside because of the gaps in the market or because of the failure of the components industry to measure up to the requirement. There is also the position of multinational companies that manufacture in this country who also do not buy their components in this country itself. The Secretary of State referred to this in Questions in the House not long ago and mentioned the Vauxhall position. What is being done to try and improve that? This is the kind of thing we want to look at because, when you look at the performance of the components industry, it seems to be declining in this country and a gap is now growing between what is being exported and what is being imported into this country. The report seems to be complacent when quite obviously there needs to be a more dynamic look at it.

(Sir *Brian Hayes.)* I would like to suggest that one really needs to look carefully at the paper which the Department submitted, the basic paper. I do not believe that to be a complacent paper. I believe it indicated a number of areas in which the industry is facing very considerable difficulty and, indeed, areas in which it has declined over past years. I would say myself the industry is now more or less marking time. We are no longer in a state of decline, as far as one can judge, but about the challenge of the future it is very difficult to say. There are a number of factors which make it a very difficult challenge for the industry to meet. You mentioned the question of local content. As you may know, we have had intensive discussions with multinational companies about that very question and Ford have said they plan to manufacture 70 per cent of UK requirement in their UK plants and to increase to 80 per cent the UK content in those cars. Vauxhall announced further investment in Ellesmere Port will result in the output of cars or private vans rising from the equivalent of 56 per cent of UK sales in 1980 to almost 64 per cent in 1986. Then in addition Vauxhall have said they aim to increase the UK content of the vehicles they build here from an average of 50 per cent in 1985 with the aim of achieving about 60 per cent by the end of 1986. So a good deal of progress has been made in the talks with multinationals on this question. But perhaps I could make one general point here: the component industry will succeed, like any other industry in this country, if it is competitive, if it is efficient, if it produces goods which can be sold at prices which are acceptable to the buyer. There is no way in which it could be made to succeed without those conditions being met, and the aim of the Department of Trade and Industry is to help the industry to meet those requirements. That is why we give substantial aid to enable them to introduce innovation, to carry out research and development, to improve their competitiveness; but ultimately the test lies with the industry itself, not with the Government.

104. Would you not agree that it is more difficult when talking in the components industry in terms of volume if a lot of cars that are being manufactured here have components that have been bought from outside the UK? Does that not make it very difficult to generate the volumes?

(Sir *Brian Hayes.)* I agree entirely with that. Even more important is the decline in actual volume of car production in this country which we have seen in the last ten years. That is perhaps the main factor that makes life difficult for the component manufacturer in this country. If one looks at the figures and sees that Germany produces four times as many cars as we do, is it any wonder that a component manufacturer finds life easier in Germany than he finds it in the United Kingdom? Of course, one way of meeting the challenge of volume is to seek export markets and to some extent that is done, and it is done very often with success. It is more difficult because there are obvious advantages in being close to the assembler who is buying the component from you, but it can be done and a number of British companies have very successful operations.

Mr Maxwell-Hyslop

105. To what extent has fear of, or actual, unreliable supply of UK components induced car assemblers in the UK to second source?

[Mr Maxwell-Hyslop *Contd.*]

*(*Sir *Brian Hayes.)* I would find it hard to say to what extent. To some extent clearly that has been a factor in the past. I suspect it is much less a factor now. The general performance of this industry, as of so many others, has improved materially over recent years.

106. Do you have actual information about whether the trend towards second sourcing components in the UK vehicle assemblies is an increasing trend or a decreasing trend? That is really what I am asking. At one time, because of an insecurity of supply, second sourcing was regarded as essential; at another time low unit cost, which is antipathetic to second sourcing, was regarded as being of primary importance. What is the existing position as you perceive it?

*(*Sir *Brian Hayes.)* I will ask Mr Cochlin to comment. Then I would like to add a word to what he says.

*(*Mr *Cochlin.)* I think the indications at the moment are that the UK assemblers are moving away from sourcing from several companies in favour of concentrating on a single supplier. It has not been the case in the past but I do not think that is a UK trend, I think it is a European one.

*(*Sir *Brian Hayes.)* That was my impression too. I hoped to hear Mr Cochlin say precisely that. When one has talked to people in the industry, they have all emphasised that performence is better, you can rely to a greater extent on the single supplier, and that there are advantages in doing so because of the relationship with that supplier and the extra volume it brings to his own business.

107. Lastly, has the DTI discussed with the Department of Transport the potential economic effects of standardising a requirement on laminated glass rather than toughened so as to avoid the duplication of output, the enlarged inventory which two different materials for windscreens can make and which many of our competitors avoid because their domestic legislation requires standardisation on laminated glass? Is this something which your Department has taken up with the Department of Transport?

*(*Mr. *Mantle.)* The short answer to that is, no, we have not taken the initiative to discuss, nor has the Transport taken the initiative to discuss with us.

108. Transport does not have the prime responsibility for the economics of vehicle production, does it? That is primarily a matter for your Department rather than Transport?

*(*Sir *Brian Hayes.)* I think the point you make is a very valid one. I think we should take it up with the Department of Transport and will do so.

Chairman

109. Could I ask you about other departments, the Department of the Environment, for instance, where you have issues which are of concern? Do you have discussions between the departments? What is their nature?

*(*Sir *Brian Hayes.)* Yes, we do. We have a great many means of keeping in close touch with other departments. For example, we co-ordinate all the work on research and development through a Vehicle Advisory Committee chaired by the Chief Executive of Lotus which brings together representatives not only from Department of Trade and Industry but also from the Ministry of Defence, the Department of Transport, the Science and Engineering Research Council and so on. We have a regular quarterly meeting with the Ministry of Defence on vehicle and component issues, and frequent contact with the Department of Transport on a whole range of issues, including the joint adminstration of the Quiet Heavy Vehicle 1990 programme. There are a number of other matters on which we have regular contact with other departments. Perhaps that enables me to make another general point, which is that I personally believe the most valuable thing the Department of Trade and Industry can do is not so much what it does itself directly with industry but ensuring that every decision of government, by whatever department, takes due account of the interests of the industry which that decision affects. Other departments take many decisions affecting industry which have more effect, I suspect, on industry than the decisions which we take, especially given the constraints on our own budget, and it is highly important that we should ensure that those decisions take due account of the interests of every industry in this country. We seek to do so.

110. With reference to the committee you mentioned at the beginning, would it be possible for you to let us have a list of the members of that committee for our

Chairman *Contd.*]

nformation, and the subject matter which hey have been looking at over the last year?

*(*Sir *Brian Hayes.)* Yes, certainly.

111. It would be of help to the Committee. In the area of the role of the DTI, do you have an interchange of personnel between the DTI and industry and *vice versa*.?

*(*Sir *Brian Hayes.)* Yes, we do, not as much, frankly, as I would ideally like, but it is a policy of the Department to have as much interchange with industry personnel as possible and we seek to do that by seconding people out for two years, say, and taking people in for two years. At the moment we have one official who is with GKN but does not have direct dealings with the components side of GKN. We have had exchanges, because it is normal to exchange people, when we have taken somebody from GKN or Dunlop or Courtaulds and they have taken someone from us. In two cases the people they took from us have never returned to the Department. This is one of the risks of this particular game but it is a risk I believe we ought to run. I do rather wish there were people prepared to leave industry and join the Civil Service but that seems to be too much to hope for!

112. We shall watch your career with interest! Do you exchange at all with other countries—France and Germany, for instance—to study their sponsorship of their industry?

*(*Sir *Brian Hayes.)* Not on a structural basis, no. We have sent people to ENA, for instance, and they have gone into the French Department of Industry and seen how they do things, but we have not lent them people who have worked in their Department of Industry for a long time.

Mr Crowther

113. Could I ask one or two questions on the Government's general policy towards the industry and the assistance you are able to give. You have kindly supplied us with memoranda on the West Midlands initiative and we do not want you to go through all the information you have already given us, but can you tell me, is the West Midlands initiative intended to be primarily targeted towards the motor vehicle components industry or do they come into it merely incidentally?

*(*Sir *Brian Hayes.)* It is not specifically targeted towards the motor components sector but, of course, there is a traditional concentration of automotive components suppliers in the West Midlands so the general schemes and general initiatives benefit them particularly simply because they are there. I will not go through all the figures but I think the figures are quite impressive in terms of the number of companies who have taken advantage of the general scheme and the way in which those numbers have increased during the period of the West Midlands initiative.

114. To what extent was the West Midlands initiative introduced because of problems arising in the components industry?

*(*Sir *Brian Hayes.)* It was introduced because of problems which arose all through West Midlands industry, not just the vehicle components industry but more widely as well, but I must admit this was a major factor in it because obviously it was the decline of the vehicle manufacture and the ultimate decline in component manufacture that loomed rather large in the overall decline of industrial activity in the West Midlands, which thankfully now has been reversed and is increasing again.

115. Do you feel that there is scope for any new initiative from your Department or are you satisfied with the level of assistance which is now on offer?

*(*Sir *Brian Hayes.)* No department is ever satisfied with the level of assistance it can offer but we all have to work within the macro-economic policy of the Government, which is a policy adopted very largely for the benefit of industry. We cannot expect, I think, to get large new resources for new initiatives at a time when every effort is being made, in conformity with the Government's general policy, to hold down public expenditure and public sector borrowing, and, of course, if one were to get a lot of extra resources they would have to be paid for either through taxation or through borrowing and that represents, in effect, a tax on the rest of industry. So I do not think it would be realistic to expect to get very large new resources for new schemes in this area or, indeed, probably in others.

116. Has all the assistance which is already on offer been taken up?

*(*Sir *Brian Hayes.)* If the Treasury were here I would be more careful in what I said but the fact is that we do try to ensure that all the assistance we are able to give is taken up and have great success in doing so. You

[Mr Crowther *Contd.*]

do not find heavy underspending on our schemes, and I believe this to be absolutely correct, because when Government decides a certain amount of money will be spent on trying to improve the efficiency and effectiveness of British industry it is up to us to see that it is spent and spent effectively and economically, and that we seek to do.

117. Do you monitor the effect of the assistance you have given? When a firm has been assisted through any of the schemes available do you keep an eye on the way it is operating and see that the money has been well spent?

*(*Sir *Brian Hayes.)* Yes. We have not done as much of this in the past as I think is desirable but we are doing much more now. We have set up an Evaluation Working Group which examines what is happening with our schemes and does try to follow up to see what has happened to individual companies who have taken advantage of the schemes. I feel this is highly desirable because it enables one to judge the respective merits of particular types of aid and, therefore, to assess one's own priorities and divert money perhaps from something less successful to something more successful. I do not think any of them fail but the degrees of success vary.

Chairman

118. Do you have any direct initiatives in the motor components industry arising from any of your innovation programmes or electronic support programmes?

*(*Sir *Brian Hayes.)* That are specific to the motor components industry, no. Obviously the motor components industry benefits, though, from schemes which are of particular application to them but also of application to other industries as well. Flexible manufacturing systems is an obvious one which has great implications, not just for particular motor components industry manufactures but other types of manufactures.

119. Have any of the motor component companies come to you and said, "Can you help us"?

*(*Mr *Cochlin.)* May I distinguish first between research and development support and support towards capital investment. In research and development we as a division do have a specific budget (£12 million currently) which is exclusively for the support of the motor industry as a whole, and the components sector obviously has a major chunk of that. The scheme works on a responsive basis and, indeed, we do get approaches from many companies in the industry. We currently have around 100 research and development cases which we are supporting under SFI, the Support for Innovation Scheme.

120. This is in the motor components industry?

*(*Mr *Cochlin.)* Yes.

Mr Crowther

121. The reason I asked the question about the level of takeup of assistance on offer was because of your Table A in the memorandum you have supplied to us, which we have marked M32. In Table A you are showing the amount of assistance on offer from 1982–83 to November 1985 and in the next column the assistance takeup to date. There is a substantial gap between assistance offered and what has been taken up and I asked the question because I am surprised by your answer.

*(*Sir *Brian Hayes.)* It may be it is based on a misunderstanding of what is meant by the amount offered. The amount offered means the amount offered towards the total cost of the project over a number of years and that amount is offered and taken up. The amount actually paid is the amount actually handed over within the course of the period in question, so that there is more of this expenditure to come. I always get foxed myself by this because people talk about offers and we think there is somebody offering £5 notes and nobody is taking them. This is not the case. The offers are, in fact, taken up. I expect occasionally a company will cancel the scheme because for other reasons they do not wish to go ahead with it. These are commitments to pay money.

122. I think I understand that point now. One of the worrying features about the information you have given us is the balance of trade and it is clear that the export-import ratio has moved very substantially against us in recent years. Do you feel there is anything more that your Department can do to improve the competitiveness in relation to oveseas competition than you are doing at the moment for this industry?

*(*Sir *Brian Hayes.)* It is not easy to see what extra we can do within our current resources. We do a lot by way of direct help to people in export markets through the British Overseas

Mr Crowther *Contd.*]

Trade Board but, as I was saying earlier, the test here is how competitive and efficient the supplier is and we are putting money into the various schemes for assistance to innovation which are intended to help suppliers to become more competitive. I think in most cases where that assistance is given it does have that result but the export market is not an easy one to crack. Given the developments in this country which have tended to raise the level of imports of components, it is not perhaps surprising that the ratio has gone as it has. I do think the components industry here does labour under an immense disadvantage in having so low a level of vehicle manufacture in this country because it is so much easier to sell to a local assembler than to sell to an assembler in another country, but I do think also that the presence of multi-nationals can be a help in this regard because it should be possible to persuade the multinational assembler in this country that components supply is so good, of such a high quality, and priced so reasonably, that it would pay him to use those components in his other plants outside this country as well, and I hope that that, for example, will be one of the benefits that comes from the Nissan investment in the North East.

Mr Hoyle

123. Sir Brian, you touched on this problem earlier on when you said there had been a decline in manufacture. You also touched slightly upon the position that a lot of those who have been manufacturers had a local content in relation to components. Do you not see that the slight balance that we have in trade is going to disappear altogether unless something is done? You are talking about the future because of what has been happening in the past in relation to manufacture and assembly here. Surely we can see in the tables that it is declining all the time, apart from the fact that it recovered slightly in 1984. Is that not going to disappear because of all the factors the one of low manufacturing is going to affect the local content?

*(*Sir *Brian Hayes.)* As I said, the local content is now increasing on the part of the two multinationals to which I was referring. I did not refer to Peugeot and Nissan but perhaps I could in fact do so. Nissan, of course, are intending, if they go ahead with phase two of their operation, to move up to 80 per cent local content. That should supply a new market for component suppliers in this country. In the case of Peugeot-Talbot one hopes to see an increase in the volume of UK production at the company's Coventry plant which would not reduce the need for tied imports but which should provide more scope for domestic components suppliers. Peugeot-Talbot have said they are willing to continue broadening their discussions on how many components might be sourced from UK suppliers. So I really would not say, "Let us draw a line on what has happened over the past ten years and continue it till it goes off the end of the graph." I do not believe that to be the case. I do believe there has been a change over the last two or three years, and I believe there will be more in the future, and the industry can take advantage of it. But that will depend on the industry rather than on the Government.

124. What I have been asking about right the way through—and I think my colleagues have too—is this: there seems to have been complacency in relation to the situation as it is with not enough being done, perhaps, directly in regard to components or the manufacturers to try and rectify the situation. For instance, you have just referred to Nissan and said 80 per cent of local content will be promised by them. What is the 80 per cent? Does it include sales? What does it mean in components themselves? Do we know whether Nissan is talking about buying 80 per cent here? Are they talking about Europe and not particularly this country? If they are, they are our competitors and we are not going to get much from that. So could you define a little more closely what you mean by 80 per cent? What is being done? when Nissan talk about local content, do they mean UK rather than European?

*(*Sir *Brian Hayes.)* It is 80 per cent on ex-works price, so it is by value, not by weight. That means all the labour costs, for instance, are counted in the 80 per cent. It is still a very significant figure. BL always said if you were tied to 80 per cent of the content you had to source the main components internally and they always said notably the engine. That is not necessarily the case but certainly it pushes you very strongly in that direction. So I think 80 per cent is a reasonable figure. Obviously one would like it higher but I do not believe it would have been possible to get a higher figure in negotiation with Nissan. Sometimes one is asked "Why don't you insist on 100 per cent?" I think the answer is, first, that if one insisted on 100 per cent the inward investment would not take place, the company would either go to another European country or not come at all;

[Mr Hoyle *Contd.*]

secondly, that we have no legislative power to insist on anything of this kind. Our power to insist only comes as a result of the assistance which we give which we make conditional on local content figures. The second question you raised was, does local content mean local content. It has to mean, since we are a member of the European Community, European Community content because it would be a breach of the Community law were we to insist that local content should mean content sourced in the UK. But, of course, if you have got a plant setting up in Washington, it must be to the advantage of that plant to secure its components as near, as far as possible, in the country in which it is located. The Japanese in particular are used in Japan to having their components suppliers very close and they like that. They like the "just in time" operation where the component arrives about an hour before it is needed—whether we ever move to quite that situation in this country remains to be seen. I would have thought the sheer economic facts mean that, although the rule relates to Community sourcing, the bulk of that must inevitably be UK sourcing.

Mr Crowther

125. I have one other point on a slightly different matter. One of the documents you sent to us in response to a request made at a previous meeting of this Committee sets out tables of companies in the components business and we have marked it M34 for reference. Table 1 is an alphabetical list of those automotive component suppliers operating in the United Kingdom with an automotive turnover in excess of £10 million per annum. I cannot see the British Steel Corporation on this list. Why is that?

*(*Sir *Brian Hayes.)* I must ask my colleagues.

*(*Mr *Mantle.)* The British Steel Corporation is not on the list because I took it as a raw material supplier rather than a component supplier although some manufacturing effort goes into the raw material.

Mr Crowther: I think it is a strange interpretation. But it is your interpretation; I must accept it, of course.

Mr Porter

126. Could I take you back to one of your mysterious tables, Table D on the document we have marked M32?

*(*Sir *Brian Hayes.)* I am afraid we have not got the code numbers.

Chairman: The document "Financial Assistance to Major Automotive Component Suppliers" at Table D.

Mr Porter

127. What concerns me is this: how many requests were made to the DTI as against the number of offers made by the DTI? Would you have that information?

*(*Sir *Brian Hayes.)* I think we could provide that information. I do not think the figures would differ all that widely because, unless the company find it quite impossible to meet the conditions of the scheme, they will in fact secure the assistance that the scheme provides. But, of course, the conditions of the scheme can be quite testing. Usually one is looking for a special proof of additionality, meaning the project will not go forward, or will not go forward on the same timescale or on the same scale, without the assistance. We have to insist on that because otherwise we are simply giving a running subsidy to the industry. The purpose of the assistance is to make something happen that would not otherwise happen.

Chairman

128. It would be interesting to see the demand coming from the industry. I think that would be of interest to the Committee.

*(*Sir *Brian Hayes.)* We will certainly try to provide that information.

129. Could I ask in terms of Nissan—and I do not suppose you will be able to answer this off the cuff—what is the total Government assistance being given, directly or indirectly?

*(*Mr *Cochlin.)* It is £35m in terms of selective assistance under section 7. In addition to that, they have an automatic right to regional development grants, which would add about £70m to that, so the total is just over £100m.

Mr Hoyle

130. Could I take you back to the export side again? In your memoranda you say there are 250 major motor component manufacturers. How many of these have significant export business?

*(*Sir *Brian Hayes.)* We think roughly 60 of the large—and medium—sized component

[Mr Hoyle *Contd.*]

companies have a significant export business but we do not have detailed figures for every company. This raises another general point about our export companies. We do not insist on great returns and statistics from every company. It would be a burden on the company and, in fact, would not help us to do our job in any case, so we do not have detailed information about the exports of every company but we do know enough about them to say there are 60 with a significant export business and I have had singled out to me 16 of particular significance. I was rather pleased to see that of the 16 I have had personal dealings with ten.

131. Looking at Table 4, trade in motor vehicle components, and looking at our exports to the EEC compared with imports from the EEC and also looking at one other, Japan, where we have a large deficit between what we export to Japan and what we import from them, what is being done in relation to these companies to try to get them to export more to the EEC, to be more competitive, and what is being done about the trade from Japan?

*(*Sir *Brian Hayes.)* What we cannot do, of course, is give any sort of selective export subsidy. We do not do that. We do, however, have an Export to Japan unit in the Department of Trade and Industry which tries to help companies generally, not just in the motor components sector but more generally, to develop trade with Japan, though that is a very difficult business to do. As far as Europe is concerned, again there is assistance from the British Overseas Trade Board with things like fairs and exhibitions and a certain amount of financial help for breaking into new markets if it is a new market for the company concerned, but generally speaking, as I was saying earlier, it is for the company itself to provide so good a service or product that it breaks into the market under its own steam.

132. But taking trade with Japan generally, if you look at those figures the gap is getting wider rather than decreasing. Are you not concerned about that, and while you say it is a difficult market, what are the holdups? What are the real difficulties of getting into the Japanese market as compared with others?

*(*Sir *Brian Hayes.)* It is one of the critical features of the world trade scene that the Japanese market is so difficult to get into. That is why one welcomes what the Japanese government has said it will do to encourage imports, and one hopes that will bear fruit, though it seems to be a rather painful and slow process. Anybody looking at Japan's trade balance with a $40 or 50 billion trade surplus must be concerned by it. It is a destabilising factor in the world trade situation and one wants to see it corrected as soon as possible, and if some part of the correction could take the form of export of motor components to Japan, that would be lovely.

133. You started off by saying you do not give any subsidy to motor components that are exported. Have you any knowledge of any of our competitors who do give subsidies to component or other manufacturers that help them to export?

*(*Sir *Brian Hayes.)* No, I have not. One often hears people say they believe there is a certain amount of government assistance given by one means or another which enables a supplier to price lower than he otherwise would. We always say, "If you can produce evidence for that we will certainly check it out." The Government is very anxious to prevent unfair trading practices of that kind. The European Community has very clear rules on the subject. The European commission is currently prepared to apply them but one does need the evidence in order to do it. As far as suppliers outside the Community are concerned, again the Community has shown itself prepared to take anti-dumping action and it is right that it should do so. I believe that is the most effective way of making sure these practices are kept in check.

134. The reverse of that is, if you have no evidence of any subsidies being given, have you any evidence of restrictions being imposed on component imports going in? We know the Japanese lay down very strict regulations, not only on cars but other things. We have heard of the French having regulations which affect motor vehicles and the Germans, and Spain has high tariff barriers to jump. What are you doing about these kinds of restrictions when you talk about free trade?

*(*Sir *Brian Hayes.)* This is the central point in the Government's policy towards the community, to try and make the single market a reality. I entirely agree there are still a large number of trade barriers of one kind or another within the Community.
We are trying very hard in this area and supporting the Commission in the efforts

[Mr Hoyle *Contd.*]

they are making to get these barriers removed. As far as Spain is concerned, we are, of course, bound by the Treaty agreement first, which was made with Spain by the then Community in 1970, and now the Treaty of Accession with Spain, so that we cannot, as it were, alter what is in those treaties but, fortunately, the arrangement for exports of British cars to Spain is going to improve materially as a result of the Treaty of Accesssion.

Mr Maxwell-Hyslop

135. On that specific point, this Committee, as you know, monitors the performance of British Leyland because of the public investment in it and we have read in the press that British Leyland have had to suspend export of 300 cars to Spain because of harassment by the Spanish Customs, who are holding up (it was reported) 1,300 British Leyland cars on entry into Spain. What action and how vigorous is any action being taken by HM Government about that?

*(*Sir *Brian Hayes.)* The problem here is that there is not yet a finally agreed allocation of the overall quota, the reduced—duty quota of 32,000 vehicles which is to be applied in five years. That is a great pity because the year began on 1 January and it should have been agreed by then. I do understand that agreement and an announcement are very close now, so that that particular problem ought to be resolved.

136. Is it the EEC Commission which is holding this up or the Council of Ministers or the Spanish government?

*(*Sir *Brian Hayes.)* The agreement lies between the Commission and the Spanish government, but I would not wish to distribute blame. It is a fact that things take a long time to resolve in the Community but I am told this one is very close to resolution and I hope the result will be such as to please British Leyland and, indeed, I have reason to believe that is so. Meanwhile, we have the problem of the vehicles that are in bond in Spain and the Spanish Government have made arrangements to pass through Customs a number of those vehicles. We are pressing hard at the moment for them to increase that number so that the trade is not held up at all pending the final application of the quota. As I say, I am told the final allocation will take place very soon now.

137. By what date will there be complete reciprocity as to freedom from quota and freedom from tariff on cars exported from Britain to Spain as compared with cars exported from Spain to Britain?

*(*Sir *Brian Hayes.)* In seven years' time from the beginning of this year.

138. Is it an annually decreasing disparity?

*(*Sir *Brian Hayes.)* It is phased, with the heaviest cut in the tariff coming in the early years, so that within three years the tariff is halved. That, of course, starts at 37 per cent, or even higher. That is the tariff. The reduced-duty quota is about 17 per cent and the European Community's tariff is only 4 per cent, so the disparity is very great.

Chairman

139. Can you help us with a mystery on the statistics in your Table 4, revised, compared with Table 4A. Table 4, revised, is trade in motor vehicle components, and you have set this out at current prices and in the 1984 statistics exports exceeded imports. If we turn to the next page, at constant 1980 prices exports appear to be less than imports. This is something to do with the exchange rate, is it, or is there something else?

*(*Sir *Brian Hayes.)* I am going to ask our statistician to explain this. I am ashamed to say, although I spotted the same apparent defect, I have not had time to take it up with him. It seemed to me extremely strange when at current prices the one exceeds the other but when you use the constant it is the other way round. I do not understand it but I am sure Dr Butchart does.

*(*Dr *Butchart.)* I hope that is true. The explanation lies in the price indicators that are used to bring the current price figures to 1980 prices. In the case of exports these have been rising on the face of it rather more sharply than those for imports. I am not sure what the implications of that are, but that is the explanation. It is the price deflator or the indication of price that is used to bring the current price figures——

Mr Maxwell-Hyslop

140. Could you speak more loudly please?

*(*Dr *Butchart.)* It is the indication of prices that we use to bring the current price figures in Table 4 to the constant price figures in Table 4A. The rise in the export price indicator has been rather more rapid than the rise in the import price indicator.

Chairman

141. So which one should we believe?

*(*Dr *Butchart.)* Well, you can buy financial

Chairman *Contd.*]

ıtures now, so you can buy pounds in 1986 rices but you cannot buy 1980 price pounds,) I would believe Table 4.

142. But if the Committee is to say it is a ood thing or a bad thing which is going on the motor components industry in terms f imports and exports, should we talk about 984 as Table 4 revised or talk of 1984 in able 4A? One shows we have a positive alance of payments; in the other it is egative.

*(*Sir *Brian Hayes.)* I think we ought to give ou a further table, Table 4B, in which we se the same deflator for both sets of figures. o my mind that is a perfectly legitimate way f making a comparison and it would leave ıe relativities unchanged because, in fact, in ach year the effect would be the same.

Chairman: That would be very helpful.

Mr Crowther

143. Could I ask a similar question? Vhether the answer will be readily available do not know. Can you tell us within the ɔtality of exports roughly what percentage is epresented by components which are going ıto new vehicles in the process of ıanufacture overseas and what proportion going into spares in stock?

*(*Sir *Brian Hayes.)* I do not think we can o this, but if we can—— No, I did not think ve could. It is extraordinarily difficult. You ould need to have returns from the ompanies themselves, if they knew, to the xtent that they knew what was going to appen to their exported components. I feel ve cannot do it. You cannot even do it by aking assumptions because there is bviously going to be a very different pattern omponent by component. Some omponents are never renewed. I must say very component in my car seems to be!

Mr Maxwell-Hyslop

144. Could you remind us, Sir Brian, nder the present state of the law on fair ompetition inside the United Kingdom, hether it is presently legal for ıanufacturers to charge outlets for identical arts very much more if they are going as pares than if they are going to original quipment manufacturers? I know this uestion has been tossed around a lot. I am ot talking about the retail price to the onsumer; I am talking about the ex-factory rice for the same quantity, say, a gross or a ıousand.

*(*Sir *Brian Hayes.)* The question, is this legal?, I cannot answer. I do not know whether Mr Cochlin can.

*(*Mr *Cochlin.)* I think the answer is probably, yes, it is legal but—— We will find out for you. I cannot answer it.

145. It would be helpful to have a note on that point because it touches obviously on the question of loss leading, on getting components which may have an undesirably short life into a manufacturer's specification for a car, and then selling the same components at a greatly inflated price to the consumer when he needs to replace them.

*(*Sir *Brian Hayes.)* It is a highly relevant point. I think we ought to give the Committee a note on it.

Mr Woodcock

146. Finally I have a couple of questions on competitiveness. First of all, do you believe the United Kingdom's components industry is competitive in the field of electronics?

*(*Sir *Brian Hayes.)* I think, if I may say so, the question is really rather too generally phrased for me to give a yes or no answer. In some aspects of vehicle electronics we are highly competitive, right out there as world leaders, and I think I could apply that description to the engine mapping system of Lucas. What that means is electronic engine management so as to get the best possible performance out of the engine. This is perhaps one of the main respects in which you can apply electronics to improve the performance of the car. One of the things it does obviously is to maximise the effective use of fuel. I am always amazed by the fact that only 20 per cent of the thermal efficiency in motor fuel gets through to the wheels that are driving, which is almost incredible.

Chairman

147. I should not worry, Sir Brian. Steam engines are 4 per cent.

*(*Sir *Brian Hayes.)* But in that respect, as I say, we are probably in the lead. Then there are smaller companies—perhaps I ought to quote two—which again have done extremely well. Econocruise Ltd have developed a micro-processed-based cruise control unit which is going to be supplied to Austin-Rover for the XX model. That actually had support from the DTI in its development. Then Lamerholm Ltd, another independent company, have developed a

[Chairman *Contd.*]

knock sensor which again we have supported and it is developing successfully a cheap and simple sensor suitable for mass production. The firm supplies Austin-Rover with all their requirements for Maestro and Montego and they are following up export possibilities. So that those are areas in which, yes, we are well up with the competition on electronics. I would hate to say that across the whole field of vehicle electronics we are fully competitive. I do not believe that to be so. I think that it is a field in which we have to succeed if we are going to succeed in this area generally, because I do believe vehicle electronics and new materials are two areas in which component supply is going to change most over the next ten or fifteen years.

Mr Maxwell-Hyslop

148. Can I ask about a third one? In so far as you can tell, what is your forecast about the trend, particularly in smaller cars, from manual gear change to automatic? If there is a positive trend in that direction, to what extent do you see Britain losing out in suitable automatic transmission units? Here you have not just the British proportion of the automatic transmission market—I am certainly enquiring about that—but the relative gain percentagewise of the automatic transmission proportionate output compared with the manual because this has always, has it not, been the element in which cars of 1500 cc and below have tended to have the smallest proportion of automatic transmission because there are not suitable ones available. Could you share with us your forecast as to British component performance in this field?

*(*Sir *Brian Hayes.)* I will ask Mr Cochlin and Mr Mantle to do that in detail, but I would say generally I do believe automatic transmission is going to become increasingly common in vehicles of all sizes. It seems to me that the whole trend generally speaking is towards a more sophisticated and easier to drive vehicle. This is bound to happen. If we do not get into that market, then that will be another area in which we fail, but I would not myself like to assume that we shall necessarily fail to get into that market. Perhaps I could ask Mr Mantle to comment.

*(*Mr *Mantle.)* I do not think we could give you a figure at this point. We would have a look at it for you as to what the assemblers' likely views are as to the development of automatic transmission. I think there is an additional point; it is not just automatic gearboxes themselves, but there will be associated electronics which will need to be developed, and possibly with its potential for increases in fuel efficiency one would hope there would be continuously variable transmission for smaller cars being developed in the future. At the moment there is not an effective one on the market. There are a number that are ineffective, and so one would expect increasing activity both in the assemblers' industry and in the associated gearbox manufacturers as well as on the electronics side. But I could not say that we shall do it in five years.

149. There has been extensive development abroad in that field which was expected to go into production and has not proved satisfactory, so fingers have already been burnt fairly heavily in that field. Do you see that as discouraging further development in that field or merely not adopting the mechanical principle employed in that actual system?

*(*Mr *Mantle.)* I think that particular instance you are thinking of was a setback and it tended rather to diminish enthusiasm for continuously variable transmission as a whole, certainly in the car rather than in the commercial vehicle. There are other forms of continuously variable transmission, one of which is patented in the UK and which is being developed. It is early to say but there are signs of good fuel efficiencies coming out of that and one might look at that kind of automatic gearbox coming into the commercial vehicle market. Certainly there is evidence that they could be put into a car but it is not certain when that is likely to happen. I think we shall definitely see it on the commercial vehicle first.

Chairman

150. Do you have any discussions with your opposite numbers in the Ministry of Defence about the way in which they have sponsored research and development into such devices as fuel management systems?

*(*Sir *Brian Hayes.)* Yes, we do. We meet them regularly on R & D matters.

151. Are you not surprised that work which has been commonplace in this country for over ten years in this area had not been actively promoted by those companies which had been sponsored by the Ministry of Defence in terms of jet engine development?

*(*Sir *Brian Hayes.)* I would not like to imply any criticism of the companies but there is a general problem here of getting the

[Chairman *Contd.*]

results of Defence-funded research into civil application and we have not been good at that in this country. It is one of the weaknesses of our system. Quite why this should be so I am not entirely clear, though steps are being taken to improve the situation.

152. Do you not feel you have to exercise an initiative here to effect this transfer, particularly when the companies in question frequently operate in both the defence and automotive field?

*(*Sir *Brian Hayes.)* Yes, I do believe it is largely for Government to ensure that at least the opportunities are looked at. One cannot obviously compel companies to take them up and it does seem surprising that in some areas companies which have a technology they have developed for defence purposes and which has obvious civil application have not pushed that through on the civil side. Quite why this is I do not know and it is probably a question better addressed to the companies themselves.

Mr Woodcock

153. Could we move to lead-free petrol. Are you satisfied that the components industry will be able to make an adequate response to the introduction of unleaded petrol?

*(*Mr *Cochlin.)* We are not aware that any of the assemblers in the UK will have particular problems in providing the engines to cope with unleaded by the date fixed.

154. Could I ask you about high-tech components. Do you believe the sale of them will depend upon Britain being able to produce high-tech motor cars and are we being squeezed out of that market?

*(*Sir *Brian Hayes.)* I am not quite sure what is meant by high-tech motor cars. If one means volume cars with high-tech features, I believe as time goes on all cars will have such features. We have to be part of that and I do not see any reason why we should not be. I mentioned the success that Lucas have had with one such feature, and although obviously we strike the basic difficulty of low volume of production, we have a lot of inventiveness in this country and I do not see why we should not have success in this country. If you mean cars like the MG XE, which was shown by Austin Rover at the Frankfurt Motor Show in 1985, that has shown we have this capability in this country, as other countries have. If one means high-quality cars which incorporate a large range of high-tech features, we have a number of such companies and there ought to be opportunities for the components sector there. But this brings one back to the basic problem all the time. Whether or not we take up these opportunities, whether or not we succeed, is going to depend on the companies themselves.

Chairman: One last point: you sent us a document "Commercial in confidence", which we will not refer to in public, concerning the components sector and there are some items in there, such as items 5(3) and 5(4), which we would like to write to you about to seek some further information. Thank you very much for your courtesy in appearing before us and the helpful way in which you have enabled us to go ahead with this inquiry.

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